June 20, 1980

Criminally Committed Mental Patient Services: A Task Force Report

Roger V. Endell and John E. Havelock

Summary

Until 1980, criminal defendants found incompetent to stand trial or not guilty by reason of insanity were committed under contract, at the discretion of the Alaska Division of Mental Health, to Atascadero State Hospital in California, a facility suitable to longer-term care of persons needing a secure setting. Changes in California state policy foreclosed this option. The most likely facility in Alaska that could accommodate this class of patients was Alaska Psychiatric Institute (API) in Anchorage; however, introduction of a few new patients with special security needs would have impacts on existing programs of the Institute. This report presents recommendations of the Task Force on Criminally Committed Mental Patient Services for placement and treatment of criminal committed mental patients at Alaska Psychiatric Institute.

CRIMINALLY COMMITTED MENTAL PATIENT SERVICES:

A TASK FORCE REPORT

JUSTICE CENTER

University of Alaska, Anchorage
Anchorage, Alaska

CRIMINALLY COMMITTED MENTAL PATIENT SERVICES:

A TASK FORCE REPORT

Prepared for the Alaska

Division of Mental Health and Developmental Disabilities

by

Roger Endell

and

John Havelock

The Justice Center
University of Alaska, Anchorage
June 20, 1980

TABLE OF CONTENTS

I. MEMBERSHIP

Participating members of the Task Force on Criminally Committed Mental Patient Services included:

Robert Bowers, Mental Health Advisory Council

Aron Wolf, M. D., Mental Health Advisory Council, Alaska Psychiatric Association

Verner Stillner, M. D., M. P. H, Division of Mental Health and Developmental Disabilities

David Coons, M. D., Alaska Psychiatric Institute

Raymond Leidig, M. D., Department of Institutions, Colorado

James L. Scoles, Division of Mental Health & Developmental Disabilities

Mason Robison, M. D., Alaska Psychiatric Hospital

John Pugh, Division of Social Services

Charles Adams, Criminal Justice Planning Agency

Richard Hacker, Department of Public Safety

Charles Campbell, Division of Corrections

Victor Carlson, Superior Court, Alaska Court System

Brian Shortell, Public Defender Agency

Roger Endell, Justice Center, University of Alaska

John Havelock, Justice Center, University of Alaska

Dean Guaneli, Department of Law

II. PROBLEM SETTING

In two meetings lasting two days each this spring, a special task force convened by the Commissioner of Health and Social Services[1/] (hereinafter the Commissioner) met to consider a variety of problems posed by the pending return of a number of patients committed under Title 12 of the Alaska Statutes. The Justice Center of the University of Alaska, Anchorage, in cooperation with the Criminal Justice Planning Agency in the Office of the Governor, was requested to coordinate Task Force efforts and to complete a report of the group's work and recommendations.

Up to this year, longer term patients committed to the Commissioner's care by reason of a judicial finding that the person is incompetent to stand trial (hereinafter "ISTs") or not guilty by reason of insanity (hereinafter "NGIs") have been committed under contract, at the discretion of the State Division of Mental Health, to Atascadero State Hospital in California, a facility suitable to longer term care of persons needing a secure setting. This option is now foreclosed by reason of changes in California State policy.

The Commissioner must now provide institutional services in Alaska for all persons, in this category, newly committed to her care. Some of these will definitely need a secure setting.

1/ In Alaska, Mental Health and Corrections are both divisions within a consolidated state Department of Health and Social Services.

In addition, over the next year or so, accommodation must be found for the five remaining patients now at Atascadero. The Alaska Psychiatric Institute at Anchorage would appear to be the only facility in Alaska that could accommodate this class of patients. The goal for the Task Force was to determine what adaptations would be necessary to accommodate to the new circumstances.

In the case of both returnees and new referrals, the numbers involved are small - perhaps a dozen new admittees per year in the latter category, most of whom would be discharged within the same year (though there is some indication that the number will grow with the implementation of a locally based treatment program). However, the problems posed are substantial in that the introduction of just a few new patients with special security needs imposed on the existing environment of API will impact a wide variety of programmatic responsibilities of the Institute.

People who are committed to custody via criminal process who also suffer from major mental health problems pose issues for custody and treatment requiring the cooperative interaction of a spectrum of mental health, social service and criminal justice agencies. The statutes, on the other hand, which describe the procedures by which these persons are to be managed, reflect differing stages of legal theories respecting the nature of human rights, personal responsibility and social defense. At every turn of the Task Force's investigation, the need to reexamine from an interagency perspective, in the light of state of the art knowledge, the laws, policies and procedures which determine how these patients are classified and treated was evident.

Patients classified as "Title 12" may have been charged by the state with, or have committed, criminal acts ranging from minor misdemeanors (trespass, failure to appear) to the most serious of felonies (murder, rape). Other patients may have been charged with violation of local municipal ordinances and committed under Title 12 for either evaluation or treatment.

While all three types of patients may require inpatient services, a significant proportion of those patients being examined in anticipation of trial (E & Os) may not, and could be seen locally, either by private practitioners or by community mental health center professionals. Examinations completed locally are usually far less costly and may be completed more expeditiously than inpatient examinations at the Alaska Psychiatric Institute (API) where per diem rates are more than $190 a day, and staff resources are already strained.

Unfortunately, however, API is obliged to accept court referrals, whereas outpatient facilities, public or private, are under no such compulsion. The key to referrals turns out, too often, to be "who pays the bill?" The much more expensive in fact API facility is used because it has no choice and referral is therefore easy while the lower cost outpatient facility is not used because costs will be drawn from a different pocket, the court budget, which must be shared with many other competing needs.

By the same token, Title 12 referral is swift and state supported. Civil referral under Title 47 is not. Here again there is a tendency to use the criminal justice system despite higher costs for a basically civil problem that has no public budget allocation. While this report highlights the need for an

entry screening system to assist the court in determining custodial cases, there is also a need to address this dysfunctional budget system.

Though the exceptions are of great importance from a fiscal and procedural perspective, most patients found not guilty by reason of insanity or incompetent to stand trial require inpatient treatment, usually in a secure setting. For these reasons, specialized programs must be available and have historically been the responsibility of the State. In Alaska, these services are only available at the Alaska Psychiatric Institute.

The Psychiatric Security Unit at API (the "PSU"), which opened in April 1977, houses a mixture of "NGI's", "ISTs" and "E&O's" who, apart from their individual medical needs, are subject to differing legal classifications and requirements. In addition, this unit with a capacity of only 14, must also be used for correctional transfers (mentally ill residents of the state's correctional system) who require inpatient treatment. With such a limited capacity, it is not surprising that for many years the Commissioner has opted to send mental patients with longer term needs for secure treatment out of state.

As PSU patients progress in treatment, some are moved within the hospital to less secure units. Persons found not guilty by reason of insanity are not released or put on an out-patient basis, however, unless the court approves such a move. Most patients who are hospitalized because they are incompetent to stand trial must eventually be returned to face the charges once competency is regained. However, a court may dismiss charges

if the patient is not likely to become competent. The "E&O's", those patients who are undergoing a psychiatric examination in connection with a criminal trial, are also returned to court for further proceedings upon completion of the examination.

The professional staff at API must work closely with the courts and prosecuting and defense attorneys in providing services to "Title 12" patients. They may be called upon to provide testimony as expert witnesses in these cases. This may include testimony regarding competency to stand trial, lack of criminal responsibility on the part of the defendant as a result of mental disease or defect, or testimony concerning the relative dangerousness of a patient found not guilty by reason of insanity.

As the population of Alaska grows, the number of criminal proceedings will increase; concomitantly, the number of Title 12 patients will increase. Aside from the increase due to population growth, there have been and will continue to be increases in numbers of patients, or workloads connected with them, as a result of Supreme Court decisions. Supreme Court decisions relating to the right to treatment such as the Alto[2/] and Rust[3/] opinions have had an impact which is not yet exhausted.

The Committee reached a small number of firm conclusions essential to a solution to the immediate problem. These conclusions will first be stated by number, followed by a discussion of the findings and reasons which impelled the Task Force to reach them.

2/ Alto v. State, 565 P.2d 492 (Alaska 1977).

3/ Rust v. State, 582 P.2d 134 (Alaska 1977).

In addition, the Task Force identified a number of related operational issues for the Division and in some cases reached some tentative conclusions as to approach which the Task Force believed should be brought to the attention of the Commissioner but which are not essential to the immediate task. These identifications or recommendations are scattered throughout the text.

The principal recommendations follow.

III. RECOMMENDATIONS

1. The present practice of responding to almost all of the evaluation and observation orders of the court (patients hereafter referred to as "E & Os") in the single psychiatric security unit within API (hereinafter the "PSU") must cease.

2. To effect recommendation Number 1, the Commissioner should send an advisory bulletin to the presiding judges of each judicial district explaining the problem and offering alternative dispositional orders or procedures to apply to persons now committed to API under E & O orders.

3. With the cooperation of the court system, the Commissioner should move to establish a court-associated preliminary screening system (either a person or a panel depending on the circumstances of the community) which could advise the court as to the type of E & O or other dispositional order which would best suit a charged person's mental circumstances.

4. A distinction should be made between E & Os and persons coming before the court who appear to require immediate mental health care. Where possible, the latter category of persons should be committed civilly, either voluntarily or involuntarily, under Title 47 rather than through Title 12. Fiscal or other inappropriate incentives to the utilization of Title 12 over Title 47 and fiscal disincentives to utilization of Title 47 over Title 12 should be removed.

5. The Commissioner should involve Community Mental Health centers and the private mental health treatment sector in addressing the needs of persons described in Recommendation 4 and in supporting E & Os who may be determined, after screening, to be proper subjects for E & O outside of a secure setting.

6. Patients now housed at Atascadero may be returned to API, over time, one at a time, according to the recommendations contained in the individual treatment plan of each patient.

7. The director of API shall assign any returning Atascadero patient to wards and treatment programs as he believes appropriate, including considerations of security, but not assigning a patient to the PSU solely because the patient comes in under a Title 12 order.

8. Allocations of existing funds shall be made or new funds requested as necessary to establish an additional closed unit at API to be operational January 1, 1982, properly designed and staffed.

9. The Commissioner should initiate a review and evaluation of all commitment and treatment statutes from the perspective of their application to the criminally committed person with mental health problems and mental health patients with conduct problems which engage the criminal law.

IV. JUSTIFICATION

A. Evaluation and Observation

It was immediately apparent that the existing facilities at API would not accommodate even a small increase in patient load without major adaptations in both facility design and program. The existing PSU with a capacity of 14 patients operates at or near capacity. Even the relatively small number of new patients proposed to be returned from Atascadero State Hospital would impose a dangerous strain on the facility. Beyond that the Task Force had to consider the buildup that would occur from new referrals originating within the state. Returning Atascadero patients and new referrals over the next year posed the immediate aspect of the problem. Buildup of patient load in the years beyond required the Task Force to consider also a longer term response.

The immediate problem quickly brought the Task Force to focus on the existing PSU. The group did consider briefly the possibility of managing Atascadero returnees in a correctional setting such as the South Central Correctional Facility at Eagle River or the displacement of existing API populations under criminal commitment to that facility to make room for returnees. But the possibility was quickly rejected as posing major disruption to correctional programs, health problems for the patients involved and questions of constitutional dimensions with respect to patient rights.

Apart from crowding problems, the existing PSU is not an adequate facility for the treatment of longer term patients. It is small. Longer term patients need a larger living space with

more access to outdoors and recreational and rehabilitative facilities. At the present time the PSU is used for patients with prospects of short term holding only (including correctional referrals), for patients awaiting transfer to longer term facilities and for patients referred by the court for evaluation and observation. The existing PSU patient population mix is not satisfactory for several reasons. First, treatment poses significant program conflicts with evaluation and observation activities. While occasional and limited E & Os can be accommodated within a small, secure treatment facility, a substantial volume of E & O admissions will disrupt a treatment program.

Since E & Os have a high turnover rate, they tend to dominate administrative time. Since they arrive under a time pressure, they also tend to dominate professional staff time at the expense of treatment.

The E & O admittee also requires a very different professional orientation. The relationship in the E & O situation is essentially adversary. The professional is working for the court. The patient may be working for a legal position. Part of the professional's task is to weed out false symptoms and to distinguish between the neurotic and psychotic. A person who, from a medical standpoint may be in need of mental health care, even inpatient care, may still not meet the legal standard. The patient may be forced to persuade the doctor that he is sicker or sick in a different way than is the case in fact. The standard of best interest of the patient is compromised by the directives of the criminal law and judicial prerogative. On the other hand, in

the treatment mode, the physician-patient privilege is applicable. The focus of the professional is on cure.

Lastly, inherent in the E & O situation, and aggravated by the absence of an earlier screening or diversion activity (of which more later) many E & O patients are originally inappropriately placed in the secure setting or are not severely mentally ill. A mixture of patients with highly differentiated mental capacities also poses risks of patient-by-patient exploitation.

Accordingly, the Committee concluded that a separate facility, involved in treatment only, was essential in the long run though use of the PSU for treatment programs might be acceptable as a temporary expedient.[4/]

To make the temporary expedient viable, some system is necessary to reduce the volume of E & O referrals to the secure unit. Task Force focus on this issue brought to light a number of present practices and procedures which are flawed irrespective of the Atascadero accommodation issue.

While there was a reluctance to identify a specific proportion of patients in this category, a substantial proportion of E & O referrals are inappropriate. Examples, for instance, might be where a person is committed based on temporary, drug-induced psychotic behavior, or where a person's behavior is aberrative but poses no risk to himself or others. First, because the cost of the E & O activity is borne by API, not the court system or

---

4/ Some incidental implications for staffing practices also arose in the review of this aspect of the problem. There are professional "burn out" and "tunnel vision" problems in concentration on a narrow class of professional activity. It is professionally desirable to provide staff with a wider range of patient responsibilities.

the patient or the private sector, there is a tendency to refer to API persons who could be evaluated in a non-custodial setting. Second, because the criminal process guarantees to the individual full cost of care, there is a tendency to treat mental health problems that have a basis independent of criminal activity as a part of the criminal act.

To amplify, a person may be suffering from mental illness which bears no direct relationship to the crime charged. If that person were physically ill, the court might refer the individual for treatment but whatever the case, the decision to incarcerate would, in the case of a physically ill person, be made largely independently of determinations respecting treatment. Where the problem is mental health, these two questions are allowed to merge. Not only do they merge with each other but they tend also to merge with the legal questions of capacity to stand trial (though trial may be many months away) and with the prospect that the patient may plead not guilty by reason of insanity (though this too need not necessarily be an immediate issue and the average person referred for E & O is most likely not to raise that defense). Since treatment is in fact the immediate need in most cases, even though a criminal charge may be pending, greater consideration needs to be given to non-API or outpatient treatment referrals and to commitment, where commitment is indicated, under civil process (Title 47). The group concluded that more information was necessary to be furnished to judges concerning commitment options available to them.

But the threshold problem is that the court is making this

E & O commitment determination in a vacuum of professional information. In most cases he is making the preliminary, screening diagnosis himself. Thus it should be no great surprise that many E & O referrals are inappropriate or that the court would err on the side of over-referral.

To meet this problem, the Task Force determined that the courts should have the support of emergency diagnosis units, utilizing whatever community mental health resources might be locally available which could assist the court with professional opinion in making the initial determination of the appropriate disposition.

A mechanism could be designed which would be utilized in each area of the state in which a jail or correctional center is located, for the purpose of providing preliminary mental health screenings in the local community. The screening mechanisms, perhaps implemented via appropriate contract language between the Division of Mental Health and Developmental Disabilities and local mental health service providers, would insure that the court would have prompt professional opinions regarding the mental status of the person before it. This screening procedure would eliminate the need for screenings to be performed at API and should reduce the need for full mental health evaluations to be performed at the Institute as well, although it would be appropriate for API to develop an outreach capacity for forensic evaluations.

Mental status screening received much of the attention of the Task Force due to its major importance and relevance to the

flow of judicial decision making and in relationship to the priorities and limited resources of API. It was determined that screenings could be completed by qualified individuals in the community mental health or private mental health sectors and that these service providers could adequately advise the court as to the need for a more extensive psychiatric evaluation and observation period (which may or may not require placement at API), a civil commitment under Title 47, or for other, or no mental health services.[5/] The Alaska Court System should expect to pay for all court ordered outpatient psychiatric or psychological screenings. In any case, court system budget constraints should not be used as a reason for referral to a more laborious, restrictive and higher cost procedure via API referral.

B. The Long-Term Title 12 Patient

Between November of 1972 and January of 1980, 30 mentally disordered offenders from Alaska were placed at the Atascadero State Hospital under an agreement between the State of Alaska and the California Department of Health. This group of mentally disturbed offenders has consisted of individuals found incompetent to stand trial or those found not guilty due to mental disease or defect. The State of Alaska has had to terminate new referrals, as of January 1, 1980. Elimination of this placement alternative has in turn created a need for expansion of psychiatric services and space at API, the only in-state psychiatric hospital setting reasonably available.

5/ Note was made of apparent statutory requirements that evaluation and observation be undertaken by a psychiatrist. However, this requirement does not appear to extend to preliminary screening or to non-custodial referrals.

The population of Alaska offenders presently housed at the California hospital at Atascadero has been reduced from fifteen (15) to five (5). There are currently eighteen (18) Title 12 patients now housed at the Alaska Psychiatric Institute, four (4) of these in the present psychiatric security unit (PSU) and fourteen (14) who are located on the wards. With the placement alternatives outside of the State of Alaska having disappeared, additional areas for long-term treatment within API are necessitated. There is a risk that API will lose its previous flexibility and flow potential for providing services to its patients. However, physical space is available at the Institute which will enable the gradual return of the remaining Atascadero patients. Increased staffing and modifications to the physical environment will be needed.

Task Force discussion focused on the need to recognize that API will keep and treat all criminally committed mentally disordered offenders and must be prepared for increasing transfers from the correctional institutions as a consequence of greater recognition of rights to treatment in the mental health setting. While recognizing that certain difficulties may be anticipated with the potential mixing of voluntarily committed patients with those who have been otherwise committed, the staff at API saw no categorical differences between Title 12 patients and others with similar mental or behavioral tendencies already there. Mental health and behavioral classifications cut across Title 47 and Title 12.

With the removal of most, if not all, court related evalua-

tion and observation patients from the limited space provided in the psychiatric security unit at API, the PSU can absorb appropriate Atascadero returnees and others needing a secure treatment facility in the short term. In the long term an additional closed security unit is required and planning should commence immediately toward its availability.

The Division of Mental Health and Developmental Disabilities has potential access to $300,000 which may be used for the necessary physical conversions. The Task Force believed it advisable for the Division to re-direct this money in order to equip an existing area of API in preparation for the shifting required by termination of the Atascadero alternative.

A FY 81 supplemental request, in order to provide immediate and essential staffing, is necessary to accompany this conversion. The Task Force estimated a need of approximately $1.1 million for the FY 82 budget. This amount will fund 25 new staff positions (the estimated number based on past experience) in order to provide appropriate staff and program for 25 to 30 beds.[6/]

Close coordination between API and Atascadero staffs can ensure that those long-term Alaska patients now receiving treatment at the California facility will be reintegrated into the API environment in a manner which will be minimally disruptive to each patient's progress and which will not nurture an "Atascadero patient subculture." With the return of these five patients,

---

6/ Readers not familiar with staff and costs of round the clock care are reminded that about five people are required to staff any position that provides round the clock service. Police and fire services have similar cost to service ratios.

with the present caseload of patients in this category now at API (18), and the anticipated growth in justice system referrals, there is no doubt that expanded facilities, staffing and programmatic capabilities are necessary.

C. Forensic Services in The Correctional Setting

Part of the population pressure on API comes from referrals from correctional facilities. The Task Force foresaw a substantial increase in this class of patient. The problems arising from the class of legal classification and treatment classification are visible here too. Persons committed to the Division of Corrections may be psychotic or may become psychotic. Just as, as a result of a legal determination, the API psychiatrist may find a person committed to his care who he has testified is not insane, so a person whose condition he has described as warranting a finding of insanity may turn up at a correctional facility. Though he may reevaluate, it is unlikely that he could find that person not now eligible for treatment on a medical standard. While establishment of a right to refuse treatment has created more of a stir in legal circles, the push in Alaska is still likely to be very much the other way. So far, much of the volume of referrals from corrections to API has been at the initiative of correctional personnel and usually because of behavioral problems disturbing to the correctional environment. But enhanced recognition by individual inmates of potential right to treatment and increased sophistication of correctional personnel in identifying mental health problems could execute a significant increase in volume of referrals.

Staffs from both the Mental Health and the Correctional Divisions report good cooperative experiences in holding and transporting offenders who are referred. The Division of State Troopers also reports no problems with transporting and/or escorting these patients. Further, the Troopers anticipate that rural justice officers especially, will develop improved ties with mental health personnel under a reorganization and training program now under way. This may well result in an increase in mental health referrals.

While the situation rarely arises, there is a need to be cognizant of due process protections when transferring correctional residents involuntarily to a mental health setting. The individual right to treatment and right to refuse treatment are concerns which must be recognized from both mental health and justice authorities.

Residents of correctional facilities have extraordinary mental health care problems in relation to the general population yet correctional facilities are not adequately staffed to meet these problems on an individual basis. The courts may also contribute to this institutional problem by implying (or stating clearly) that a given indivdual could benefit from some form of mental health therapy or treatment. The Task Force agreed that an improved service delivery system is necessary to meet requirements of correctional populations.

The problem was identified and discussed by Task Force participants as it related to the traditional reluctance of legislators to provide a "mental health" component for correctional

programs and services. Apparently only the Eagle River Correctional Center, with two counseling psychologist positions, is relatively well equipped of the nine in-state correctional centers for the provision of counseling services to inmate populations. But even there, a need has been identified for further training, assistance, and consultation between mental health and correctional personnel.

Several recent court rulings were utilized to provide examples of cases in which the mental health needs of convicted criminals were inadequately addressed. The Task Force foresaw an approach which would involve both the development of an improved, in house, mental health capacity in corrections and an outreach program, assisting correctional residents and recent residents utilizing the hospital and community mental health.

Sex offender programs and other in-house correctional treatment services can and should be provided through funding made available to the Department of Health and Social Services for the express purpose of providing mental health treatment in the correctional setting. This funding should include the training of correctional staff.

It was agreed by Task Force members that API should be recognized as a hospital and that it therefore ought to be given the appropriate resources in order to function as a hospital. However, a fully developed hospital should include the development of a forensic outreach capacity which might also serve the correctional system from the resources of API and other community mental health care providers.

It was recognized that while the recently completed Alaska Correctional Master Plan may provide for adequate attention to the physical health service needs of inmates through utilization of registered nurses, contractual M.D. services, and physicians' assistants, the plan was inadequate in describing appropriate mental health treatment mechanisms. Many offenders could function successfully in a correctional setting as long as clinical mental health services could be made available to them.

Although there are approximately 21 community mental health clinics throughout Alaska, many are reluctant to respond to requests for services from correctional or social service program administrators. The latter agencies argue that the private sector may provide better services so long as the government agencies are able to pay for them. The Task Force members agreed that future Requests For Proposals (RFPs) developed by the Division of Mental Health and Developmental Disabilities for community mental health clinical services must include provisions for the delivery of services to correctional units. An outreach capability developed by API staff should then be used to supplement or "back up" the community clinic resources. Since both the Division of Mental Health and the Division of Corrections are organizationally located in the same Department of Health and Social Services, administrative coordination of funding and policy-making should be simplified. Coordination between the Office of the Commissioner and the Court System should also be enhanced as a result of a continuing dialog.

Additionally, it will be necessary to provide at least an evaluation level of services, and perhaps long-term care arrange-

ments for the twenty (20) juveniles who still remain in out-of-state social service placements. Although there may be administrative pressures for a long-term unit for adolescents to be provided within the Alaska Psychiatric Institute's environment, it was questioned whether a long stay in a psychiatric hospital would provide the best alternative for these youngsters. Various Task Force participants suggested that placements outside the walls of an institution would be more appropriate, but that these resources do not presently exist, hence the need for further planning, eventual funding and implementation of an alternative service mechanism.

D. Review of Legal Services/Statutes

A need had been identified for a review of the present mental health statutes. The need for on-site legal support services to the Alaska Psychiatric Institute administration and staff (see Consultation Report by Raymond Leidig, Appendix A) had also been identified. In discussion, Task Force participants recognized the need for a close working relationship with the Department of Law in structuring Departmental representation versus case by case representation which too often may inhibit overall policy direction and control. In short, the Department needs a higher level of consistent legal services at the field level.

Other discussion issues included: the judiciary's practice of ordering persons to API in possible violation of the patient/institution rights; inadequate attention to community treatment and the possible alternative placements for NGIs or ISTs; institutional treatment versus outpatient care; conditional releases

similar to the present parole mechanisms; and other case issues directly related to mental health policies and procedures which may need defense strategies of a continuing and consistent nature.

The Task Force concurred with the "Leidig Report" recommendation that:

> In light of current court decisions regarding the length of hospitalization or confinement for this population of the criminally committed, a process of reviewing current statutes should be initiated to anticipate both other options for treatment as well as addressing the specific limitations of confinement that are likely to be imposed in the future. Issues regarding the right to refuse treatment and right to treatment may need also to be considered in light of a growing tendency of the courts' intervention in these areas. (Appendix A, Recommendation Number 7.)

The Task Force concluded that the Departments of Law and Health and Social Services should work cooperatively in conducting a review and evaluation of Alaska's present mental health statutes. The two Departments should also seek to develop administrative arrangements for the provision of continuing legal services which would enhance the defense of sound mental health policies and procedures with regard to the criminally committed or criminally related client.

APPENDIX A

Consultation Report

Raymond Leidig, M. D.

CONSULTATION REPORT TO THE DIVISION OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES IN THE DEPARTMENT OF HEALTH & SOCIAL SERVICES OF ALASKA

Regarding

CRIMINALLY COMMITTED MENTAL PATIENT SERVICES

by

Raymond Leidig, M.D.

April 18, 1980

Problem

As of January 1, 1980, the State of Alaska had to terminate the process of sending the mentally disordered offender to Atascadero State Hospital in California. Since November of 1972 an agreement existed between the State of Alaska and the California Department of Health for the care of the mentally disordered offender. During the fiscal years 1973 through 1979 thirty (30) such mentally disordered offenders were sent to Atascadero State Hospital. This group comprised those individuals found not guilty on the grounds of mental disease or defect and those considered incompetent to stand trial. During these same years twenty three (23) individuals were discharged from Atascadero State Hospital.

The current policy regarding this matter for the Division of Mental Health and Developmental Disabilities is to develop a plan of services including evaluation and observation and diagnosis and treatment and care of this group of offenders within the capacities currently available and those that must be planned for within the State of Alaska.

This newly created need for expansion of psychiatric security capability has been responded to by Dr. Verner Stillner, Director of the Division of Mental Health & Developmental Disabilities by organizing and convening a task force to review options and considerations and to make recommendations to the Department of Health & Social Services and the Division of Mental Health and Developmental Disabilities. This task force is representative of the following state entities:

Criminal Justice Planning Agency
Department of Public Safety
Division of Social Services
Mental Health Advisory Council
Division of Corrections
Superior Court
Public Defender Agency

Division of Mental Health & Developmental Disabilities
Alaska Psychiatric Institute
Criminal Justice Center, University of Alaska
Alaska Psychiatric Association

Scope of Consultation Activities

My visit in Alaska included the review of issues and activities and discussions with staffs at the following facilities:

Alaska Psychiatric Institute,
Anchorage, Alaska

Ridgeview Correctional Faciltiy for Women
Anchorage, Alaska

Criminal Justice Center, University of Alaska
Anchorage, Alaska

Sixth Avenue Annex,
Anchorage, Alaska

Eagle River Correctional Facility,
Anchorage, Alaska

Division of Mental Health & Developmental Disabilities,
Juneau, Alaska

I attended a task force meeting in Juneau, Alaska on April 4, 1980 and presented my preliminary review considering options and issues for the task force. During my visit and since my return I have also had an opportunity to read relevant statutes, correctional master plans, previous reports dealing with this issue and statistical reports from the Division of Mental Health & Developmental Disabilities. The greatest degree of courtesy and cooperation was afforded me by the staffs of the facilities and the task force members in my endeavors.

Review

The Alaska Division of Mental Health and Developmental Disabilities is already engaged fully in the evaluation and observation and treatment of several categories of criminal offenders. Since January 1 of 1980 it has admitted the group formerly sent to Atascadero State Hospital. In addition, it receives admissions in the Psychiatric Security Unit from various local law enforcement facilities and state correctional facilities. Because of the responsibility to the latter categories, consideration in this report is given to options that may or may not include all populations which would require treatment in secure facility settings. These populations include the following:

1. The not guilty by reason of mental disease or defect offender.

2. The incompetent to stand trial offender.

3. The correctional criminal offender.

4. The sexual offender.

5. The developmentally disabled offender.

Although my review indicates the statutes relating to the disposition of sexual offenders does not include the requirement of treatment, it is reasonable to assume for future planning purposes that the treatment of selected sexual offenders may constitute a responsibility for the mental health services in Alaska. Developmentally disabled offenders appear not to be a major issue at this time but should be kept in mind as more and more court actions demand mental health services be provided by the states for this class of people and as deinstitutionalization of the developmentally disabled progresses.

The need of secure setting treatment capability at this time should address the two primary populations: the criminally committed mental health patient and the criminal offender from local and state correctional programs.

In my interviews and discussions with various mental health and correctional professionals certain variations of perceptions of mental health capacity and mission and other controversies that are not unusual between these two fields arose. Some of the controversies are within only one field such as that of whether or not secure treatment settings for offenders should be developed in the mental health system and at mental health locations or whether they should be based at correctional facilities. There are differences of opinions amongst the mental health professionals on this issue.

Correctional staffs, by and large, indicated a need for not only more mental health evaluation and observation capability delivered through the mental health system but in addition, longer term retention of individuals referred for treatment to API. Differences of opinion occur amongst correctional staff also as to whether they should be afforded more mental health capacity in-house to the correctional system versus that which would be contracted for or delivered through the state mental health system. The treatment and security needs of the two populations, the criminally committed offender and the correctional system offender have many similarities but also have some significant differences especially in the area of progression toward final disposition. Notwithstanding those differences between the needs of the two populations, consideration can be given to secure setting treatment programs that would accommodate the bulk of treatment for hospitalized patients from both groups. Also, post-hospitalization programming and follow-up vary considerably in terms of what can be made available to each of these groups.

Alaska statutes allow for treatment other than in secure

settings of the criminally committed offender. The issue of dangerousness appears to be the determinant for utilization of hospital. The community mental health sector of the Alaska system, although not personally assessed by visitation was reviewed in discussion as to capacity for both front-end diagnosis evaluation and observation of either the criminally committed offender and the criminal offender in the correctional system and the potential capacity for follow-up services.

The private practice sector already greatly involved with evaluation for the courts and in some instances in follow-up treatment post-discharge from hospital represents a very major resource in the State of Alaska, given the geographical disbursement of populations, community mental health programs, private psychiatrists, and other private sector mental health professionals.

The seven year statistics cited above regarding admissions and discharges from the Atascadero State Hospital indicate an increased capacity of no more than 10 beds, given the assumption that that activity would remain constant over time. The ten bed increase does not assume a single ward security treatment setting. It only indicates the flow rate of the previously Atascadero committed patient and the average daily population that might be assumed, given the previous seven years activity. Atascadero State Hospital has a spectrum of security and treatment settings within its complex and some elements of lesser security settings can be envisaged for this population within an Alaskan program that may utilize either other wards of the Alaskan Psychiatric Institute when a patient is ready for such responsibility and can extend to the utilization of both public community programs and private practioners in the community when an individual can handle the open society setting.

Another assumption regarding this increased capacity is that the evaluation and observation for both the competency to stand trial and the not guilty by reason of mental disease or defect would continue on the present Psychiatric Security Unit. Bed need of a specific unit for the treatment of the acquitted population and the incompetency to stand trial population may not exeed five or six beds. The establishment of such a small unit with three-shift security treatment capability appears feasible within the current structure of the Alaska Psychiatric Institute complex. This may not need additional building but modification of a section of a ward or floor.

The above assumptions and the resultant size ward and given other program options for this population refers only to the group of people previously sent to Atascadero. I do not believe the assumptions regarding the incidence of this activity will remain constant. Further, the expressed need for longer hospital treatment of the correctional offender with a mental health need in a secure setting offers the opportunity to plan for both populations. Exact statistics regarding the need for longer term hospitalization treatment of correctional offenders from the correctional system would need to be projected if, indeed, a model for a secure hospital setting treatment unit is to be planned. The Atascadero group length of

hospitalization is far in excess of that of any general population and is usually in excess of that required for correctional system transfers for treatment.

Two documents concerning correctional master planning were reviewed. The first titled: Alaska Corrections Master Plan; a preliminary draft summary dated July 11, 1979 indicates on page 15 that a significant sharing of professional talent could be realized because the Commissioner of Health & Social Services has reporting to that office the Director of Corrections, the Director of Mental Health, the Director of Public Health and the Director of Social Services. On the same page the recommendation is that a full-time health professional be identified as the manager of the health delivery system within the central staff of the Division of Corrections. That individual, it is recommended, would manage the mental health and drug and alcohol intervention programs. No further delineation of the services expected through the Division of Mental Health & Developmental Disabilities and the other entities named is included. However, as indicated previously in this report, my interviews with correctional officials revealed the hope and expectation that the Alaska Psychiatric Institute and the mental health delivery system would be able to expand its capacity to accommodate longer term hospitalization for those in need from their system and more short term hospitalization treatment capacity plus more services provided from community mental health programs and private practioners. No accurate statistics were available regarding the need for the population requiring longer term secure hospital treatment.

Future Activities, Considerations and Speculations

Several factors that can be projected into several future scenarios must be considered now that Alaska will treat the criminally committed offender within the state. First, across the United States there has been a significant increase in the utilization of the plea of not guilty by reason of insanity or by reason of mental disease or defect. This possibility occurring in Alaska must be considered in terms of projecting any plan for additional hospital units and for evaluation and observation activities and treatment upon release from hospital units under conditional release situations. Another factor concerns the visibility of the activity now that it will be in-state and the experience and awareness of the courts, prosecuting and defending attorneys, mental health professionals, and the community at large. Increased utilization of the plea in the State of Alaska may result only from the establishment of this in-state capacity. Another growing factor across the United States is the emergence of the courts' intervention on behalf of the correctional system offender with health and mental health needs.

These factors and others combine to cause greater scrutiny of the activities and results of activities in this area. Such an in-state program and facility also causes an increased client (patient) attorney contact and thus more activity for mental health professionals in the local courts. In essence, I would project an increased utilization of the plea for the reasons given above and a significant increasedactivity in the interface between mental health professionals both in the public and private sector with the courts of Alaska.

Another area that must be considered is the adequacy of the current statutes defining the length of time of criminal commitment. I add this concern on the basis that in many states revision of the statutes referring to criminal insanity have had to be revised to insure that confinement for mental health treatment under the criminal insanity code or statute cannot exceed the time that ordinarily would match a criminal conviction with a penal or probationary sentence. Periodic review by the courts of the status of each criminally committed offender has been a usual inclusion in revision of statutes. In some states, notably Montana, Illinois, and Michigan the statutes have been revised to accommodate both a sentence of determinate time and a disposition that includes treatment. The new plea language in these states is given as "guilty but mentally ill." These approaches in statute tend to reflect a reconciliation of the ambivalence of society regarding such individuals as to whether they should be punished and/or treated.

Another factor with in-state treatment that must be considered is the attitude and skill present within the public and private mental health system in the community that would apply to this population. This group of individuals is not usually a top-priority for community mental health centers and clinics or private practioners in terms of their practice. The visibility and vulnerability that these patients present for themselves is carried over to any institution or entity involved in their treatment and care. The legal activities surrounding these individuals cause signficant additional workload for those responsible for their treatment.

Training in the core disciplines of psychiatry, psychology, social work, nursing, mental health worker and affiliated mental health professionals does not usually include the treatment of the potentially dangerous offender. Strategies for overcoming prejudicial attitudes and skill deficiencies must be considered and may possibly be solved through special orientation and continuing education opportunities afforded through the Division of Mental Health and local mental health professional associations.

Another planning effort currently in process is that of the hospitalization space and treatment needs for children and adolescents. In our discussions it was indicated that a decision has to be made regarding the opening of a new unit at Alaska Psychiatric Institute for this purpose. This factor for considration obviously affects the current capacity of the Alaska Psychiatric Institute to respond to any additional needs for the criminally committed offender and the correctional offender.

Discussion and Recommendations

The treatment of the criminally committed offender can include the full spectrum of treatment options in the modern day considered appropriate for the general psychiatric patient. This would include in-patient treatment, partial hospitalization, group treatment, out-patient treatment, other 24 hour alternatives such as half-way house programs and transitional living programs. The unique requirement of security usually is invoked in the evaluation and observation period and in the early stages of hospital treatment. It is not

impossible to consider that some individuals would not need security settings for either activity, since all criminally committed patients do not represent significant danger. Many mental health clinicians find it difficult to exercise both role of therapist and administrative control with their patients. This is less true of hospital staffs but can usually be found as a significant factor in the resistance of community mental health programs in accepting and adequately treating and managing these patients.

The issue of which setting such treatment should occur in - a mental health versus a correctional setting represents an on-going controversy and discussion in many states. In recent combined state meetings it would appear that wherever possible the in-hospital treatment setting for the criminally committed offender should be carried out in connection with a mental health service rather than a correctional facility. Both the acquitted group and the incompetent to stand trial group are not prisoners in a true correctional or criminal justice sense and thus their location in a correctional facility where the primary emphasis for the facility is security can often precipitate major and continuing legal activity as patient advocates, especially from the legal community, raise the issues of treating an "innocent" individual in a penal setting. Recruitment of qualified staff for a mental health setting treatment unit is far easier than for a correctional setting unit.

Many states have forensic hospitals and/or units within psychiatric hospitals that co-mingle the criminally committed, the incompetent to stand trial, and the correctional offender. There are segregated programs in other states and a usual segregation is for those states where sexual offender statutes require segregation and treatment either in a mental health setting or a correctional facility. There are states in which the forensic units are incorporated administratively in either divisions or departments of corrections. These tend to be in states where units were developed many years ago. Where new units have been developed the administrative entity is usually the mental health division and the location is usually either an independent psychiatric hospital or a forensic unit within a psychiatric hospital. Sizes of the various populations and the amount of activity are influencing factors to both the location of the administrative authority and the location of the programs. Recently with the deinstitutionalization of large numbers of developmentally disabled there has been an increased incidence of misdemeanor and felony offenses by this population in the community. Because this population usually is also considered by the various statutes as not responsible for such acts because of a mental disease or defect, programs for their treatment under a commitment status that requires security have been developed either in the mental health hospitals or in the institutions serving the developmentally disabled. Co-mingling of the developmentally disabled offender and the other offender groups is not the usual standard procedure. This is because of the peculiar vulnerability to exploitation by the other offender groups that the developmentally disabled can be subject to as well as the peculiar special treatment skills needed by a staff dealing with this population.

Alaska, like most states, has organized its mental health

services through the executive branch having direct control over the institutions and contracting for services through public community mental health centers and clinics and, in some instances, with private providers. The accountability requirements for those who treat these individuals is extremely high and tracks to the courts, to the legislature, and to the public at large in a very visible manner. For this reason program policies and procedures must be very specific to account for treatment and tracking of these individuals. Such policies need to be communicated through contracts to the community providers. Constant evaluation and monitoring of services to these individuals need to be incorporated in any plan to be able to account for modification dependent upon outcome of treatment services and follow-up with recidivism the prime concern of all. The factors used for the prediction of repetitive violent or dangerous acts must be constantly reviewed as to their efficacy. The science of this prediction is inexact and thus those with the responsibility must live and operate with certain risk.

Recommendations

1. The establishment of a maximum/medium type security treatment unit should be planned for at Alaska Psychiatric Institute. The size should be predicated on both the analysis and projection of use of the plea of not guilty by reason of mental disease and defect and the projection of need of longer term hospitalization population coming from the correctional system.

2. The current psychiatric security unit which handles the evaluation and observation and short-term treatment should continue that activity including the court-ordered evaluations of those under the plea of not guilty and those requested by the court for competency to stand trial. That unit does short-term treatment at this time and most likely should continue that role if the workload for evaluation and observation does not increase. There are many definitions of short-term treatment but I believe consideration for those who require 3 to 15 days hospitalization could be accommodated on this unit and perhaps even occasionally those who may require 2 to 4 weeks.

3. The treatment of women acquitted under the plea of not guilty by reason of mental disease or defect and requiring hospitalization and those for which treatment to the point of competency is needed should be considered to be carried out in the general adult psychiatric wards. Women both in criminal insanity setting treatment and in correctional setting treatment usually do not require the conditions of security found to be needed for the average male population.

4. For those individuals who are discharged to a conditional release status and who still require mental health services I would recommend specific performance contracts with both public mental health providers and private practioners for additional follow-up treatment in the community. I would further recommend paying a premium price as incentive for inclusion of these individuals in the

caseload of these providers. In collaboration with the court, the conditions set forth for conditional release must be exact and specific to the needs of the individual and the community to assure the least risk of recidivism. Such conditions should be built within a performance contract with each provider entity and monitored accordingly by either submitted reports or site visitation on a periodic basis to evaluate procedures and performance.

5. A joint analysis by the Division of Mental Health and the Division of Corrections to ascertain more accurately the projection of need for long-term hospitalization of correctional offenders should be swiftly accomplished in order to plan the size of the maximum/medium security unit for treatment. Accompanying this analysis the scope and dimensions of the projected mental health screening and direct services component of the correctional system needs to be addressed as rapidly as possible since the establishment of greater mental health capacity within the correctional system will automatically increase referrals to the mental health service system. This added system analysis may also include any community correctional programs as to the incidence of need for hospitalization from such source.

6. The skill needs of staff with the responsibility for both hospital services and community treatment services devoted to these individuals should be assessed in collaboration with the various professional societies and post-secondary education institutions to aid in establishing core educational courses and continuing educational courses and the planning for making them available to current staff as well as considering classification of such personnel to be separate from the usual hospital mental health classifications so that entry employment requirements to security psychiatric treatment units can eventually include some standard minimal level of pre-service education.

   Additional educational opportunities regarding the statutes, policies and procedures surrounding the activities for the criminally committed offender and the correctional offender treatment group should be made available to clinicians, the judicial and the bar with a planning process again including the post-secondary educational institutions.

7. In light of current court decisions regarding the length of hospitalization or confinement for this population of the criminally committed, a process of review of current statutes should be initiated to anticipate both other options for treatment as well as addressing specific limitations of confinement that are likely to be imposed in the future. Issues regarding right to refuse treatment and right to treatment may need also to be considered in light of a growing tendency of the courts' intervention in these areas.

8. A review of the internal rules and regulations and procedures governing the management of potentially dangerous and violent individuals should be initiated. Because of the longer term confinement of the criminally committed patient and the nature

of the disturbances within these individuals, staff/client conflicts resulting in injuries to staff and patients is of a much higher incidence in these units than in general psychiatric units. Women are particularly vulnerable and need assistance and education and training in both the methods of avoidance and the managing of the seriously disturbed patient in confined settings. This review activity may already be in progress as I did not have an opportunity to review the written procedures or rules and regulations governing this activity.

9. The Division of Mental Health & Developmental Disabilities should initiate a process of evaluation of the resources needed to address the increase and workload as indicated by the several correctional facilities in the Anchorage area that require both evaluation, short-term treatment, and follow-up of the clients. The Anchorage Community Mental Health system and local private providers plus the correctional facility, health and administrative staffs should participate in this. It is possible by that more outreach capacity from the mental health providers to the correctional facilities the current Psychiatric Security Unit could be relieved of some admissions which could be handled by early intervention at the correctional facility. I did not visit the community mental health center and thus cannot attest to their capacity to respond to this need. It was evident that the Alaska Psychiatric Institute capacity could not be stretched to accommodate this workload need without additional resource.

10. Planning for this responsibility should include on-site legal support services to the Alaska Psychiatric Institute administration and staff. This can either be planned in collaboration with the attorney general's office or through the program of special counsel to the Division of Mental Health if such a model of legal services is possible under Alaskan statute. The justification for this recommendation lies in the anticipated increase in legal activity precipitated by the client and attorney contacts that will emanate from the program being housed at the Institute. In addition legal services to assist the staff and administration are necessary to assist and educate in matters concerning rights of patients and rights of staff. A population of criminally committed offenders and correctional offenders in mental health treatment settings is frequently a source of litigation. Reviews of such activities constantly reveal a deficiency in the administration of treatment and security which clearly delineates rights of patients and rights of staff and the procedures attendant to those rights.

11. As with the general psychiatric treatment population in hospitals, family inclusion in treatment whenever possible should be made a part of the treatment program. With the patient now residing in Alaska for treatment family inclusion may aid in shortening the term of hospitalization as well as keeping in force those support systems for acceptance back into family and community life once discharge is possible. The inclusion of family in the progress of treatment can be affected both through the hospital program as well as through the community mental health capacity and with the involvement of private practioners where appropriate. Visitation

by family is a right of these patients and,thus, visitation capacity in terms of varying levels of security must be planned for. Contact and non-contact visitation has to be considered.

12. The current task force either in its present form or in modified form should be continued after the finalization of the plan and during the implementation phase. Excellent communication has been established between responsible entities represented on the task force and I believe this would assist the Division of Mental Health & Developmental Disabilities as it assumes this greater responsibility in the treatment of this population.

13. Alcohol and drug services incorporated within the psychiatric treatment services for this population is of necessity an important and integral element for the success of outcome. The correctional offender group, especially, will have a high incidence of alcohol and drug use related problems and the expertise of alcohol and drug treatment skill is needed.

Summary

The preceding report and recommendations are, of course, based on the knowledge acquired during my visitation and through the readings of the various documents shared with me. Certain assumptions have been made, mostly on the basis of the projection of the size of the criminally committed offender group. The inclusion of the correctional offender requiring hospitalization for psychiatric treatment, I believe, is a viable model for consideration which would relieve and resolve certain controversies to a significant degree. I was much impressed with the current knowledge and the expertise of the participating individuals that I contact with and hope that this consultation report and recommendations will facilitate the consolidation of that expertise in the development of the Alaskan plan for services to the criminally committed offender and the correctional offender.

APPENDIX B

Agency Responses

1. Division of Corrections
2. Division of Social Services
3. Department of Public Safety
4. Department of Law

MEMORANDUM State of Alaska

TO: Verner Stillner
Director
Division of Mental Health

DATE: May 20, 1980

FILE NO:

TELEPHONE NO: 465-3376

FROM: Charles F. Campbell
Director
Division of Corrections

SUBJECT: Mental Health Consultation Report

I have read with interest the consultation report prepared by Dr. Leidig and have studied his recommendations from the perspective of the Division of Corrections. The Division of Corrections is prepared to work with you toward implementation of those recommendations found by the Task Force to be most needed.

A joint analysis of needs by the Division's of Mental Health and Corrections, as suggested by Dr. Leidig, will surely identify the serious lack of in-state resources for mentally troubled young people. There is a good chance that a Division of Youth Services will come into existence in July 1981. This prospect will be addressed during the course of the development of the Department of Health and Social Services FY 82 budget. The absence of a suitable facility for seriously disturbed young people in Alaska should be considered at that time. The Division of Corrections and the Division of Social Services have had to resort to placements in the Brown School and the Devereaux School in Texas. This is a poor practice and whatever happens with respect to plans for a new Youth Services Division, this problem needs attention.

Dr. Leidig's report mentions "sex offenders" as a category whose problems need to be addressed by the Task Force. I agree, and yet it is a category which includes offenders whose criminal behavior and personality dynamics vary enormously. My impression is that they tend to have one characteristic in common, in that they are not often amenable to psychiatric treatment. The category poses a dilemma for the Division of Corrections because of the insistent belief among the public, shared by some sentencing judges, that such people need "treatment" and that the Division of Corrections should be able to provide such treatment on an almost routine basis. We would be most grateful if this Task Force could come up with some ideas as to how to deal with this perception, and if it could identify useful approaches to be taken with respect to individuals within the "sex offender" category who should indeed be provided with some form of individualized therapy before release.

The Division of Corrections has had a "sex offender" program at SCC/Juneau during the past year funded by an LEAA grant. It is essentially a group program, but we believe the program to be useful as it provides a supportive

activity for a number of individuals who might be expected to have a very hard time in prison, and suffer from a much larger loss of self-esteem than usual. Persons serving sentences for offenses involving abuse or injury or sexual exploitation of children are assigned the lowest status among their peers in prison. Although they apparently are not subjected to the same kind of ill treatment in Alaskan prisons as they would encounter elsewhere, we have the impression the sex offender program at SCC/Juneau is helpful as something of a maintenance program. It does not, however, represent much progress toward addressing the problem in a comprehensive way. (Incidentally, we enjoy the distinction in Alaska of having the highest incidence of rape in the country.) My belief is that if we could make some reasonable headway with the problem of alcohol abuse in this state, the sex offender problem would be abated significantly.

In otherwise commenting on Dr. Leidig's report, it would be difficult for me to separate discussion of the central concerns of the Division of Corrections from measures which might be specifically designed to meet Mental Health needs. In the interest of the welfare of all of the offenders committed to the care of the Division of Corrections, we believe there is an urgent need to make improvements in the settings where offenders are confined throughout the state. The correctional center at Eagle River is the only facility operated by the Division of Corrections for adults capable of providing an environment remotely conducive to good mental health. Therefore, rather than the Division of Corrections being in a position to adequately care for marginally troubled people, the unhappy fact of the matter is that we must, for the time being, rely on facilities wherein there are circumstances more likely to exacerbate mental problems than alleviate such problems.

I am especially concerned about the institutions at Fairbanks and Juneau. We house offenders at these facilities for long periods of time, sometimes for many years. There are no private rooms or cells at either facility, other than segregation cells. There is much idleness. Thanks to the ingenuity of staff and the generosity of outside resources (CETA and the University of Alaska), there are two or three good rehabilitative programs, but these programs tend to be improvised and are operated on a tenuous basis. Neither institution has adequate perimeter security which means inmates are unable to get outside as much as they should. Both institutions are understaffed and thus the inmates have limited access to staff. Conditions at Ketchikan and Nome are even worse and until the replacement for Ridgeview is ready, women offenders will continue to be housed under substandard circumstances.

On the positive side of things, the Master Plan process has called the plight of Corrections in Alaska to the attention of key decision makers in state government. As a result, the Division will be adequately funded (relatively speaking) for the first time in several years. Moreover, it appears that the Office of Alcoholism and Drug Abuse is to

be funded adequately and will be able to provide desperately needed services to the Division of Corrections in the area of alcoholism treatment. The Master Plan study revealed that about 85 percent of the Division of Corrections clientele have committed alcohol-related crimes.

Dr. Leidig's report took note of a Master Plan study recommendation that a full-time health professional be identified as manager of the health delivery system within the central staff of the Division of Corrections and that this individual manage the mental health and drug and alcohol intervention programs. The Division of Corrections does not plan to follow that recommendation precisely. We believe a better result can be obtained by way of the establishment of a new position of Assistant Director for Correctional Programs. Health care matters will be handled separately, while matters pertaining to mental health, drug and alcoholism treatment and all other correctional treatment programs will be under the direction of the new Assistant Director. We would expect to have the new Assistant Director on board within a month's time.

A number of efforts have been made to strengthen programs and improve conditions at the correctional facilities. Additional staffing will aid greatly in this regard. The degree to which the Division of Corrections succeeds in upgrading its programs is significant to the state of mental health care in Alaska. At present, the Division represents, on balance, a negative factor in the State so far as mental health is concerned. Confinement is an essentially negative experience. When confinement takes place in such a manner to subject those confined to overcrowding, lack of privacy, absence of constructive activities, and a sense of tension and hostility, sometimes for years on end, we can assume that individuals in a marginal mental state are likely to be seriously damaged by the experience, even though the damage might take the form of a confirmed sense of alienation rather than a lapse into psychosis. Therefore, we believe the Division of Corrections can best serve the cause of mental health by striving to better meet its recognized responsibilities.

Corrections and Mental Health in any jurisdication invariably take care of each other's problems. Among the clientele of Corrections, persons in a marginal status are always to be found. On the other hand, Mental Health is inevitably called on by Corrections to work with individuals who do not have the kinds of disorders which mental health professional consider to be treatable by way of accepted psychiatric methods. These individuals are usually diagnosed as having character disorders even though their behavior sometimes takes bizzare forms, to such an extent on occasions as to place them beyond the management capability of a correctional institution. A good working relationship between Mental Health and Corrections requires that the agencies of both disciplines have a great amount of flexibility with respect to managing the marginal elements of their respective clientele who perhaps might be misplaced at any given time.

At present, API has limited ability to provide anything more than short-term care and treatment of apparently disturbed Division of Corrections referrals. That institution simply does not have sufficient room or staff to work with as many cases as the Division of Corrections might wish to refer. By the same token, Division of Corrections institutions provide clearly unsuitable settings and have inadequately trained staff and indeed not enough staff to work appropriately with individuals who present the kind of mental health problems normally dealt with in mental hospitals.

For its part, the Division of Corrections intends to upgrade its overall capability for working effectively with all of its clientele. Meanwhile, the Division of Mental Health will move forward in development of plans for dealing with Title XII cases and improving its overall capacity for working with mentally disturbed patients in all categories. These plans should include development of a program for sentenced offenders who have mental problems beyond the present capability of correctional staff. The Division of Corrections would be pleased to cooperate with the Division of Mental Health in the development of such a program.

CFC/mjr

MEMORANDUM

State of Alaska

TO: Vern Stillner, Director
Division of Mental Health and
Developmental Disabilities

DATE: May 14, 1980

FILE NO:

TELEPHONE NO:

FROM: John R. Pugh, Director
Division of Social Services

SUBJECT: Mental Health Services for Children

In preparing my recommendations regarding the criminally committed mental patient I could not help but also think about the on-going need for increased services for our disturbed children. The enormous needs of these children combined with the on-going inadequacy of the service system continues to concern me. It seems inconsistant that we are planning to return our criminally insane to the state but continue to place a significant number of children in out-of-state facilities due to their emotional disturbance.

As we enter into deliberations regarding the needs of the criminaliy committed mental patient, I would hope that we might also discuss the needs of our disturbed children. In particular we need to focus on further development of community based services for emotionally disturbed children and the development of an in-state residential care component.

JP/gc

MEMORANDUM State of Alaska

DATE: May 14, 1980

TO: Vern Stillner, Director
Division of Mental Health and
Developmental Disabilities

FILE NO:

TELEPHONE NO:

FROM: John R. Pugh, Director
Division of Social Services

SUBJECT: Criminally Committed Mental Patient Services

Short Range Objectives

1. Review of the present client pool to determine the number of individuals in each of the five sub-groups.

2. Evaluation of the individuals in the sub-groups to determine the needs of each individual.

3. Inventory of the resources available in each community for the various sub-groups.

4. Development of a plan for appropriate matching of individuals with resources, with a particular emphasis on community based services provided in the least restrictive setting.

5. Development of recommendations regarding the gaps in services for the five sub-groups.

Long Range Objectives

1. Establishment of a maximum/medium type security treatment unit at API.

2. Development of community based services for all five sub-groups (with the assumption that only the dangerous/violent individuals would need secure treatment).

Sex Offender Programs

1. Need alternatives to incarceration.

2. Need sexual offender programs within the correctional facilities.

3. Need special programs to deal with the sexual child abuser and his or her family.

Staff Development And Training

1. Community providers will need intensive staff development and on-going training in order to develop services for these five groups of clients.

2. Correctional personnel need training in the handling of the criminal offender, sexual offender, and the developmentally disabled offender.

3. Social Services, Mental Health, and Correctional personnel need special training regarding the treatment of the sexual child abuser and his or her family.

4. API staff will continue to need on-going training in the handling and treatment of these client groups.

FY 82 Budget

1. Increased request for community mental health funds to specifically provide services for these five sub-groups.

2. Request for funds to develop and staff a 10 bed maximum/medium security unit at API.

3. Request for a half-time Attorney General to provide on-site legal support services to API.

JP/gc

MEMORANDUM State of Alaska

TO: Verner Stillner, M.D., M.P.H.
Director
Mental Health & Developmental Disabilities
Health & Social Services

DATE: May 12, 1980

FILE NO:

TELEPHONE NO: 465-4322

FROM: Richard Hacker Richard Hacker
Consultant
Office of the Commissioner
Department of Public Safety

SUBJECT: Task Force on Criminally Committed Mental Patients

I have received your letter of April 29, 1980 and the accompanying report by Doctor Leidig. I am attaching the Alaska State Trooper's comments dated April 23, 1980 and the appropriate back-up material. This was sent to Roger Endell of the Justice Center but your letter seems to request such reports also be sent to you.

I will briefly comment on Dr. Leidig's recommendations as they appear on pages 8 to 11 of his report.

1. Construction may be necessary but I believe we should be very cautious. Inexorably, utilization nearly always expands to fill the space available, be it highways or hospital wings. Often this leads to inappropriate or unnecessary use or simply aggravates the problem rather than alleviating it. The "analysis and projection" recommended here thus become the most important elements of this paragraph.

2. Portions of this recommendation hinge upon the construction suggested in #1. That evaluation and observation as well as short term treatment are appropriate in the Psychiatric Security Unit, I have no doubt. Longer term treatment should also be considered if new construction is not immediately advisable.

3. I support the treatment of women hospitalized under not guilty by reason of mental disease or defect (NGI) or for competency reasons within the general adult psychiatric wards.

4. Specific performance contracts for those discharged to conditional release status appears supportable and even imperative from both a case management and a therapeutic perspective.

5. The establishment of greater mental health capacity within the correctional system should be a high priority.

6. No comment on the educational aspects.

7. I suggest the review of State Statutes and current court decisions be done in conjunction with the Assistant Attorney General assigned to the Department of Health and Social Services.

8. No comment on internal procedures.

9. A resource evaluation should be undertaken in light of the impact of future corrections mental health needs but I would advise the same caution concerning construction as I did in #1 despite Dr. Leidig's statement that "It was evident that the Alaska Psychiatric Institute's (API) capacity could not be stretched to accommodate this workload need without additional resource."

10. I strongly support legal services for API. I suspect this would necessarily have to come through the Attorney General's Office. If "onsite" legal services are not possible, an Anchorage-based Assistant Attorney General who is given very few other non-API assignments should be solicited for this task.

12. No comment on the continuation of the task force.

13. I strongly support the inclusion of alcohol and drug services to these patients, especially the correctional offender group.

    Furthermore, I would like to strongly support several statements embodied in the narrative beginning on page 6 of the Leidig report under "Discussion and Recommendations." These are:

    1. The treatment of the criminally committed offender can include the full spectrum of treatment options . . . considered appropriate for the general psychiatric patient.

    2. . . . wherever possible the in-hospital treatment setting for the criminally committed offender should be carried out in connection with a mental health service rather than a correctional facility.

    3. Co-mingling of the developmentally disabled offender group is not (advisable).

The Department of Public Safety is perhaps least affected by and least involved in this treatment situation. Nonetheless, I hope our remarks have been of some help.

Attachments

MEMORANDUM State of Alaska

TO: Mr. Richard Hacker
Consultant
Office of the Commissioner
Department of Public Safety

DATE: April 23, 1980

FILE NO:

TELEPHONE NO: 269-5641

FROM: Colonel T.R. Anderson
Director
Alaska State Troopers

SUBJECT: Criminally Committed Mental Patients

As requested in your April 4, 1980 memorandum I have enclosed a report on the impact or lack of impact on the closure of Atascadero State Hospital on the Alaska State Troopers.

I believe from review of Lt. Kaufman's memorandum, that the bulk of impact will be on the API budget and their staffing problems.

cc: Mr. Roger Endell, Criminal Justice Center, U of A

Enclosure

MEMORANDUM State of Alaska

TO: Major R. Iversen
Field Enforcement Commander
Alaska State Troopers

DATE: April 21st, 1980

FILE NO:

TELEPHONE NO:

FROM: Lt. W.R. Kaufman WRK
Commander, Anchorage Post
Alaska State Troopers

SUBJECT: Agency Report on Criminally Committed Mental Patients

According to Dr. Mason W. Robinson, Alaska Psychiatric Institute Superintendent, only six or seven Alaskan patients remain in Atascadero. These will be phased back to A.P.I. gradually over the next year - as the patients are mentally and physically able.

A.P.I.'s fourteen bed security wing is now often full, so eventually they will need more space, but that is not a measurable A.S.T. problem. A.P.I. does have another unused wing, but needs additional staff.

Anchorage Judicial Section is presently called by A.P.I. to assist in approximately only one non-court transport a month. Having six to twelve more A.P.I. housed patients would effect the total A.P.I. assist caseload only minutely. Most A.P.I. patients medical problems are handled right at A.P.I. If A.P.I. sends a patient to a hospital they hire American Guard and Alert. Also there is no reason private psychiatrists can't see their A.P.I.-housed patients at A.P.I. Many do so now.

The present wing at A.P.I. has never had an escape and has not been a police enforcement problem. I do not feel even the doubling of the bed space - from fourteen to twenty-eight - would increase the need for A.S.T. assistance except for an occasional court transport.

For certain the saving of A.S.T. time and expense transporting patients to Atascadero and back will make up for any local (Anchorage) transports. The rest of the state (A.S.T.-wise) will not be effected.

Note: In the past 15 months AST has moved 19 prisoners to or from Atascadero.

cc: Captain H. Tew
Commander, C-G Detachment
Alaska State Troopers

WRK/tr

MEMORANDUM

State of Alaska

TO: Verner Stillner, Director
Division of Mental Health
and Developmental Disabilities

DATE: May 14, 1980

FILE NO:

TELEPHONE NO:

FROM: Avrum M. Gross
Attorney General

Daniel W. Hickey
Chief Prosecutor

By: Dean J. Guaneli
Assistant Attorney General

SUBJECT: Comments on the Consultants Recommendation to Task Force on Criminally Committed Mental Patients

This memorandum is in response to your letter to me of April 29, 1980, requesting comments on the consultation report prepared by Raymond Leidig, M.D., concerning the facilities at the Alaska Psychiatric Institute and the necessity for caring for criminally committed mental patients there. Although the immediate problem facing the task force is the cancellation of the agreement with Atascadero State Hospital in California for the care of dangerous criminally committed mental patients from Alaska, Dr. Leidig's report was helpful in pointing out that there are other groups of mental patients who need similar care in a secure facility. On the other hand, I found the report to be speculative in some of its assumptions regarding the legal system, particularly with respect to Dr. Leidig's belief that there would be an increased utilization of the plea of not guilty by reason of insanity, as of the result of establishing a secure psychiatric ward at API. In general, I believe that the review undertaken by Dr. Leidig was somewhat ambitious in its scope given the time constraints he was working under. Nevertheless, I think his report focuses attention on various aspects of the mental health system that require additional study and projections in terms of future needs.

My comments regarding his specific recommendations are as follows:

1. The establishment of a maximum security treatment unit at API is of course appropriate. However the size of that facility should be based on a realistic analysis on the future need of that type of facility and not on the premise that there will automatically be an increase in the use of pleas of not guilty by reason of insanity. If one makes that assumption, then the result would most likely be a facility that is larger than needed, and which will necessarily be used to its capacity.

2. The recommendation that the current security unit continue to handle evaluation and short-term treatment appears to be appropriate.

3. The recommendation concerning the treatment of women appears to be appropriate.

4. The recommendation concerning the conditional release of mental patients requires some careful thought and study. I would not like to see such a system developed solely to reduce the institutional population or because such care is less expensive. In addition, I believe that statutory authority is required for such a system and that careful consideration should be given to the constitutional due process limitations that conditional release necessarily entails.

5. The recommendation for a projection of the need for long-term hospitalization of correctional offenders appears appropriate.

6. The recommendation for training and education appears appropriate.

7. The recommendation of a review of the current statutes is appropriate. Many of the concepts recommended by Dr. Leidig are contained in the committee substitute for House Bill 2, currently before the legislature. However, it is unlikely that the bill will be passed this session so there is time for further review to be accomplished.

8. The recommendation for a review of the rules and regulations regarding the division of mental health appears appropriate.

9. The recommendation for a projection of the short-term needs of correctional offenders appears appropriate.

10. The recommendation for on-site legal services is highly inappropriate. There is currently no need for more than part-time legal assistance and certainly no justification for on-site counsel.

11. The recommendation for family visitation appears appropriate.

12. The recommendation that the task force be continued is probably not appropriate. Once the task force recommendations are prepared, the division should undertake implementation. Periodic reports could be circulated to interested persons in the justice system, but a permanent task force in unnecessary.

13. The recommendation for drug and alcohol treatment services is appropriate, assuming any such program can be successfully carried out in an institutional setting. I know that Charles Campbell, director of corrections, does not believe that such programs are successful in prisons and I suspect that his rationale is equally applicable to mental health treatment facilities.

I hope my comments have been helpful.

DJG:sl

APPENDIX C

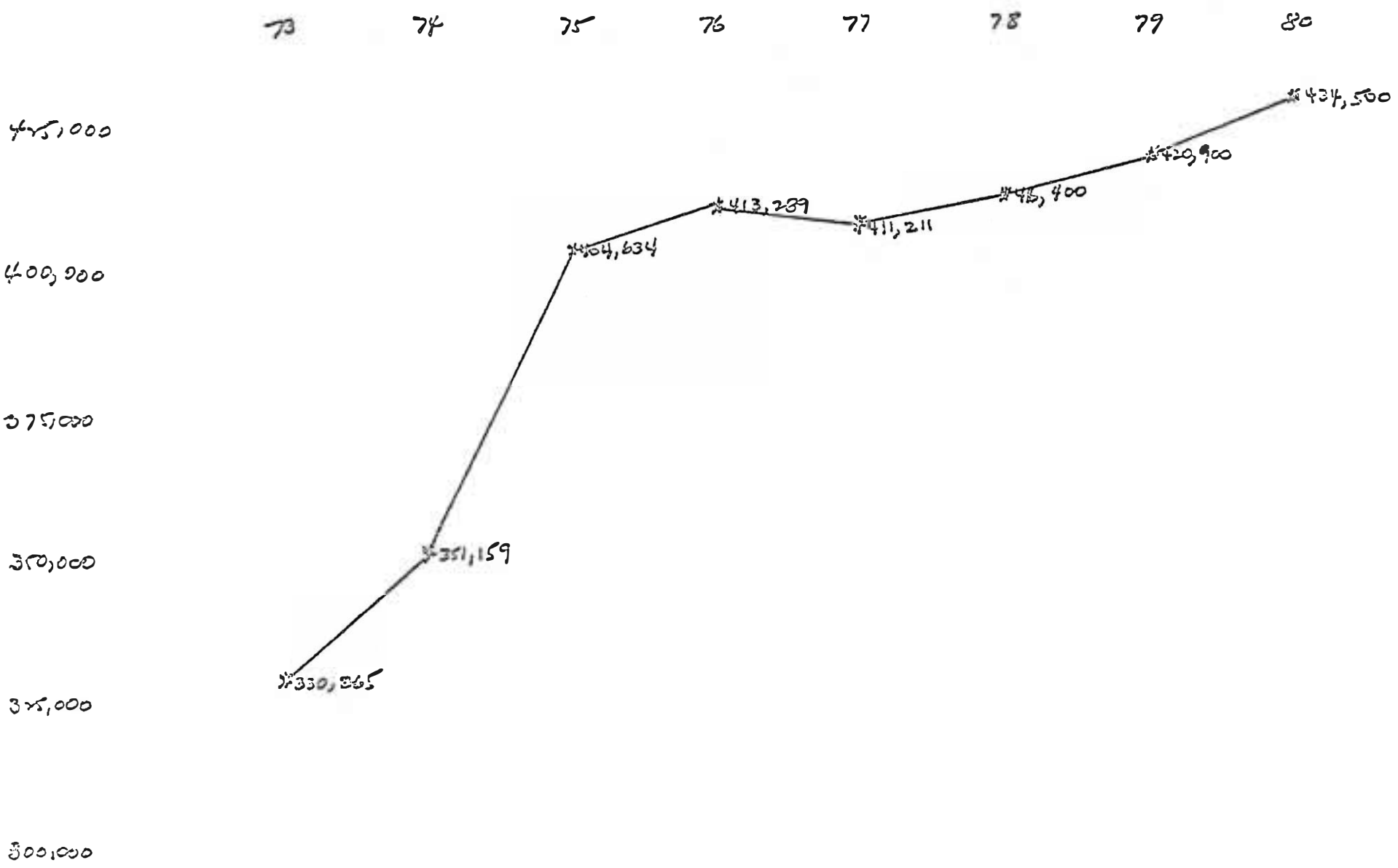
Tables

FY 1973 - FY 1980 (Projected)

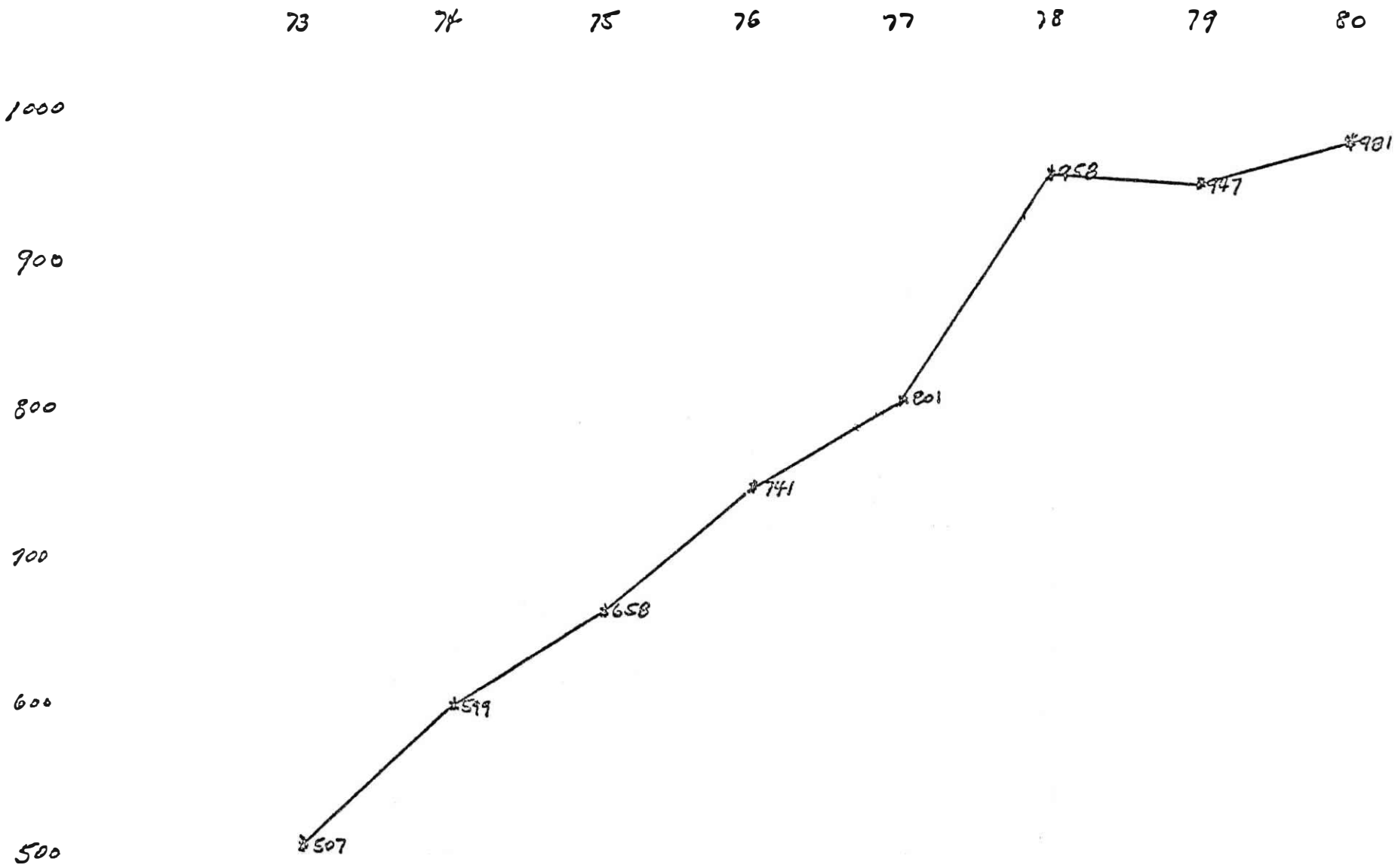
API ADMISSIONS BY TYPE OF ADMISSION

Type of Admission	FY 73	FY 74	FY 75	FY 76	FY 77	FY 78	FY 79	FY 80
Voluntary	399	456	466	353	248	228	212	298
Physicians Cert.					239	245	225	249
Judicial	42	62	100	240	85	284	202	158
Correctional Transfer				17	72	84	70	64
E & O					157	217	238	212
TOTAL	507	599	658	741	801	958	947	981

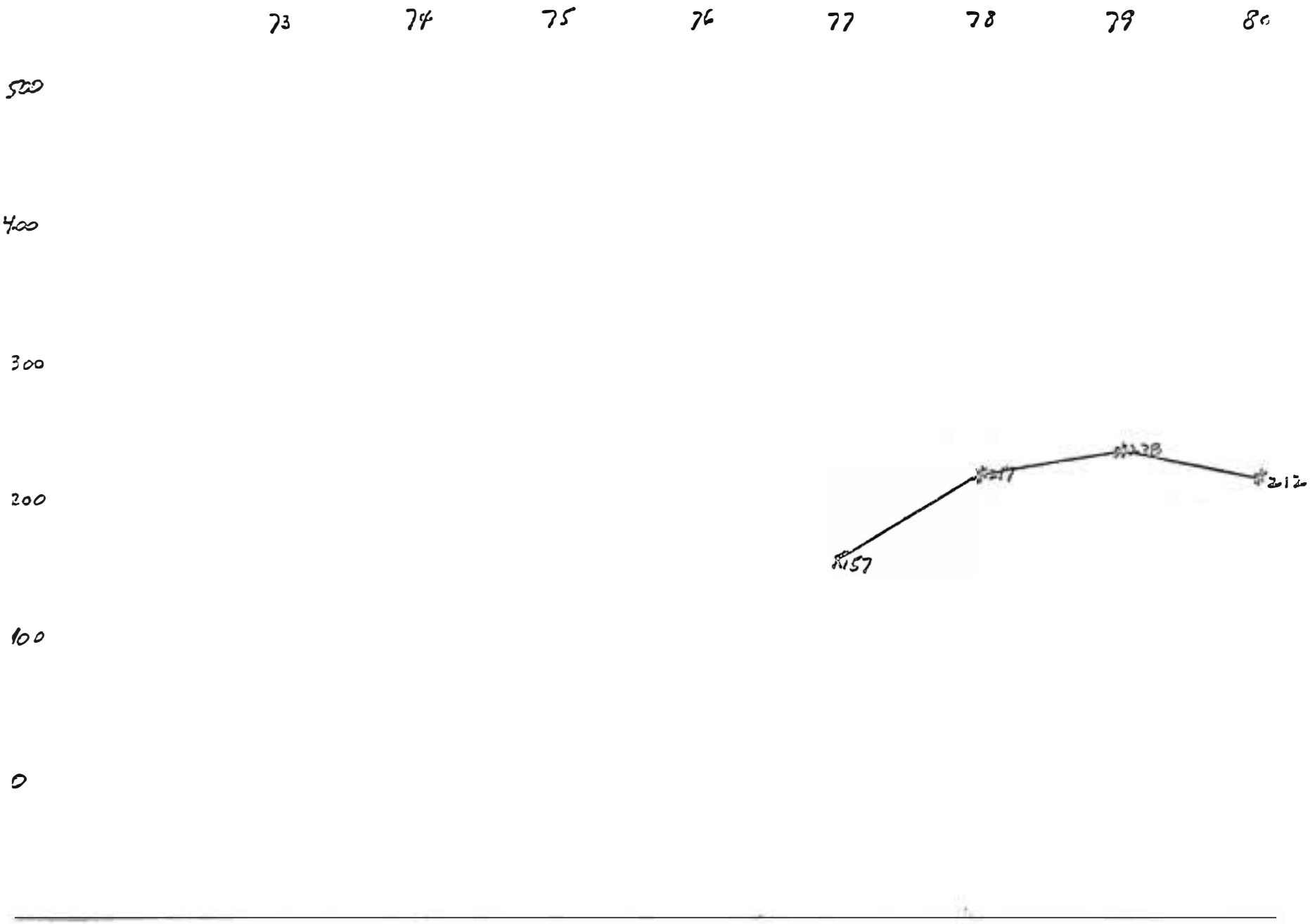
ALASKA POPULATION
FY 73 - FY 80 (Proj.)



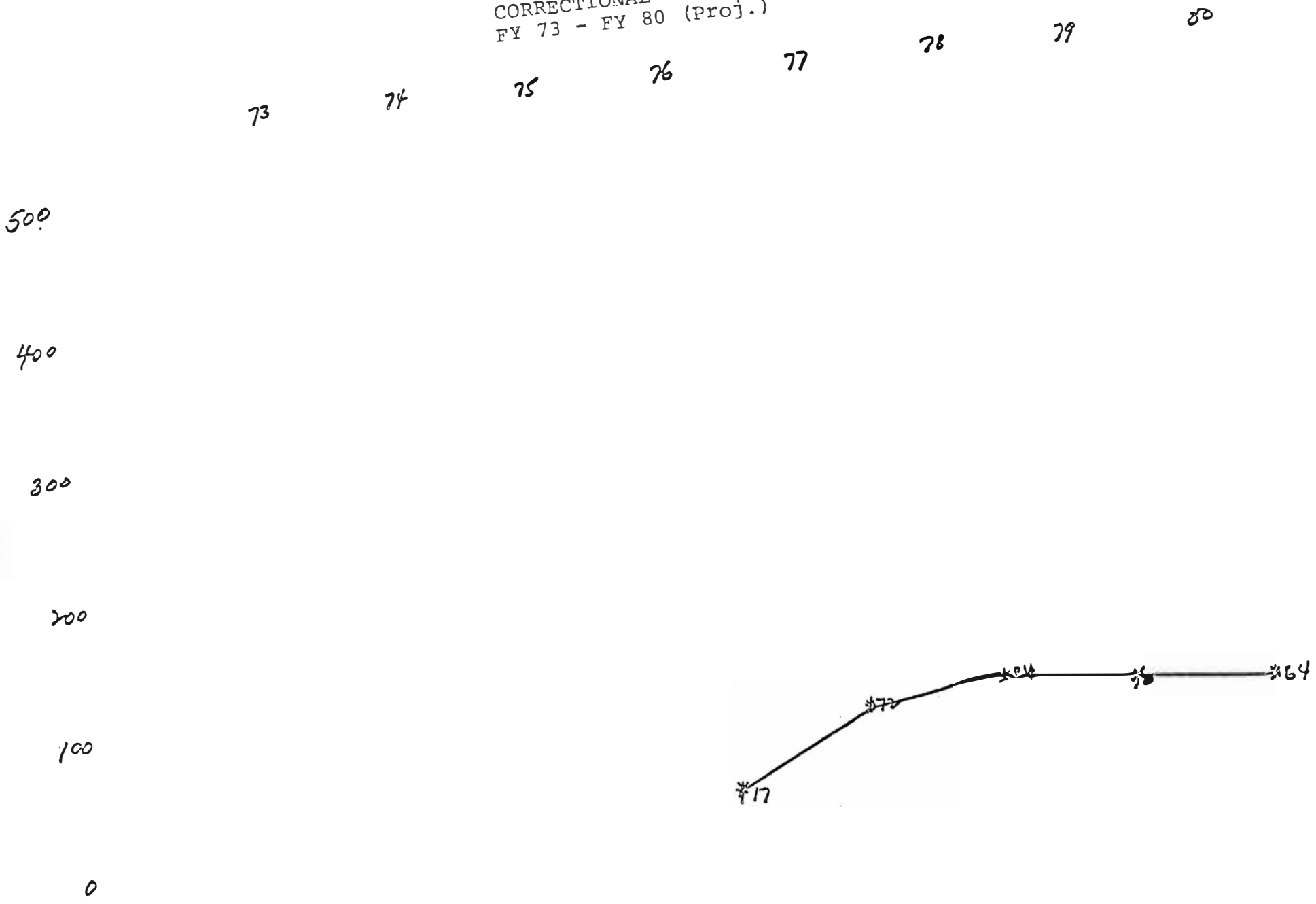
TOTAL ADMISSIONS TO A.P.I.
FY 73 - FY 80 (Proj.)



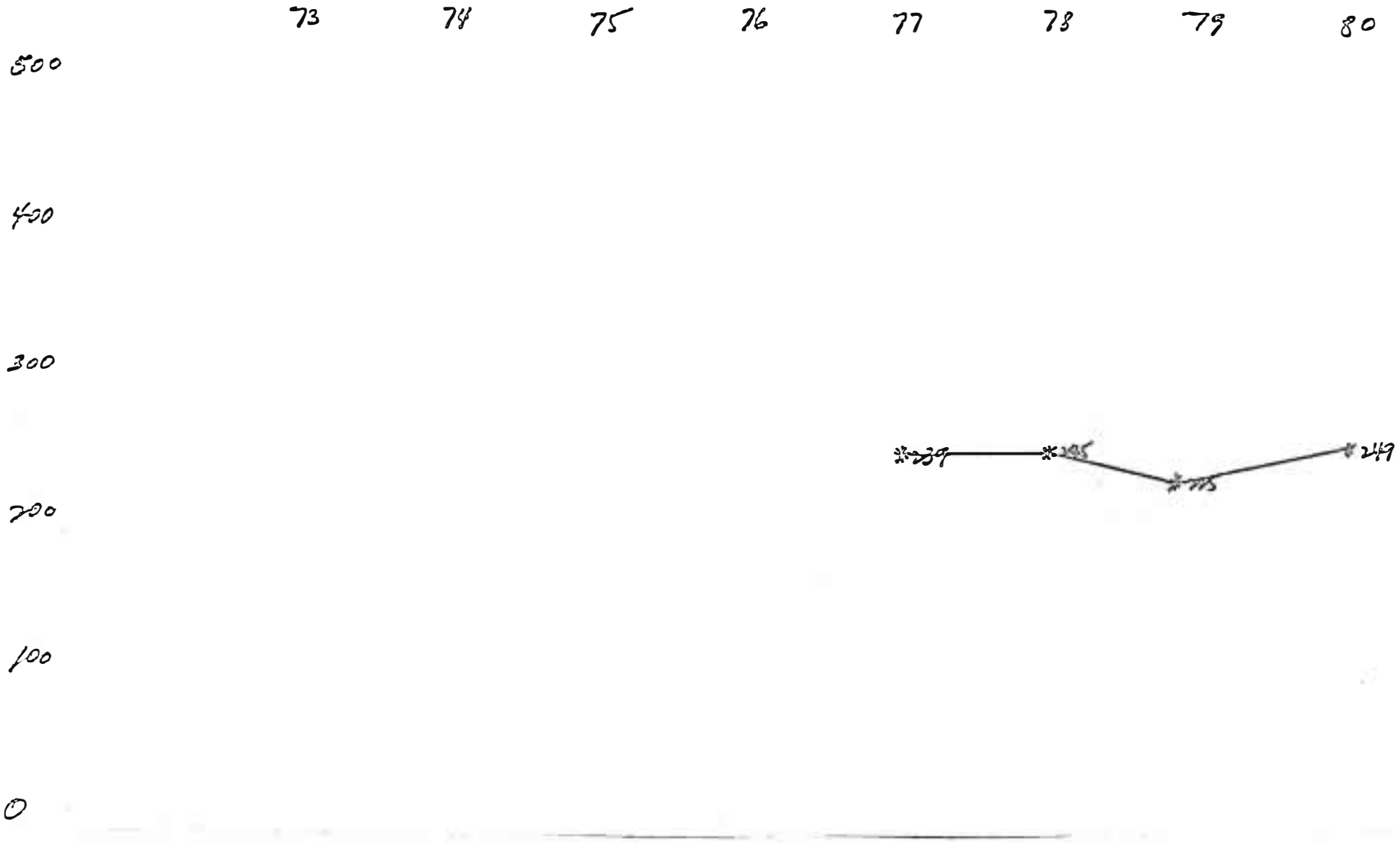
EVALUATION AND OBSERVATION
FY 73 - FY 80 (Proj.)



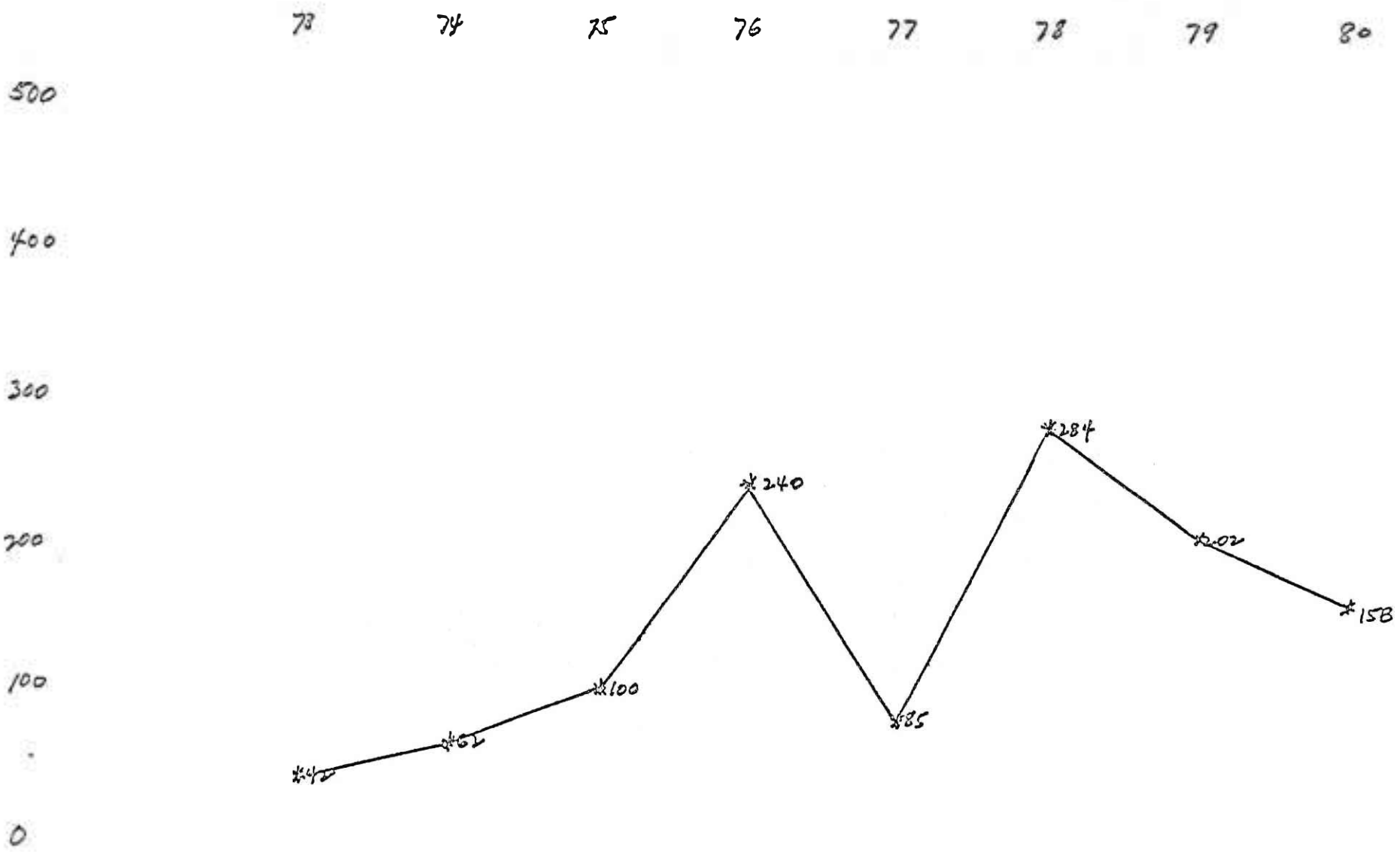
CORRECTIONAL TRANSF.
FY 73 - FY 80 (Proj.)



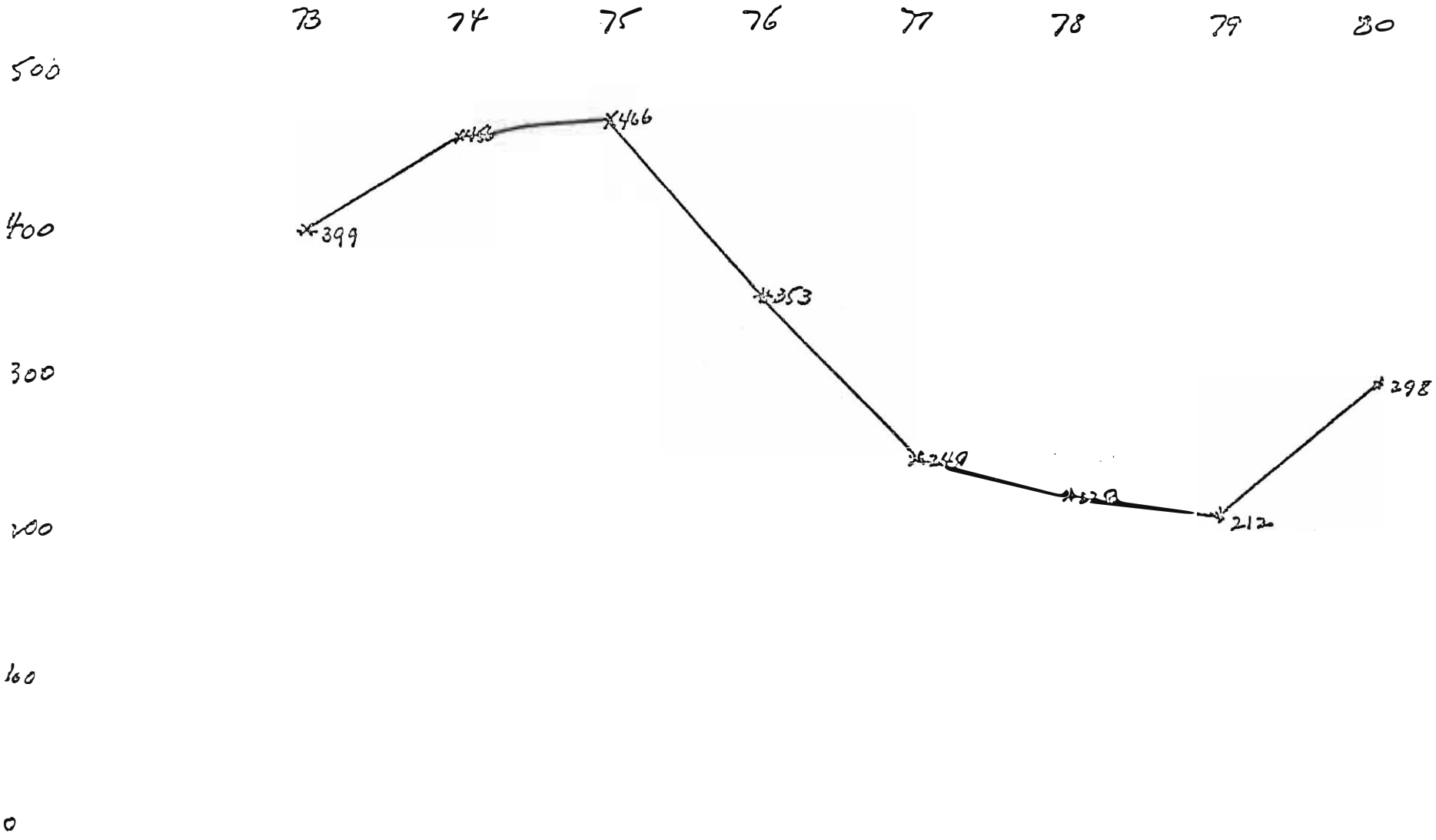
PHYSICIAN CERTIFICATE
FY 73 - FY 80 (Proj.)



JUDICIAL
FY 73 - FY 80 (Proj.)



VOLUNTARY ADMISSIONS - A.P.I.
FY 1973 - 1980



FY 1980

API ADMISSIONS BY TYPE OF ADMISSION

	July	Aug.	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Total	%
Voluntary	15	25	15	31	21	32	35	25	199	30
Physicians Cert.	21	31	8	15	19	21	27	24	166	26
* Judicial	11	14	12	18	13	10	14	13	105	16
Correctional Trans.	6	5	9	6	2	7	4	4	43	6
E & O	16	22	21	22	21	14	13	12	141	21
							TOTAL		654	

Projected for FY 1980

Total Admissions	=	981
Voluntary	=	298
Physicians Cert.	=	249
Judicial	=	158
Corrections	=	64
E & O	=	212

*Includes 13 Title 12 admissions. Projection for FY 1980 = 20.

FILE NONAME (CREATION DATE = 03/10/80)

MONTH

API ADMISSION DATA

FY 79

CATEGORY LABEL	CODE	ABSOLUTE FREQ	RELATIVE FREQ (PCT)	ADJUSTED FREQ (PCT)	CUM FREQ (PCT)
JULY	1.	77	8.1	8.1	8.1
AUGUST	2.	105	11.1	11.1	19.2
SEPTEMBER	3.	80	8.4	8.4	27.7
OCTOBER	4.	81	8.6	8.6	36.2
NOVEMBER	5.	71	7.5	7.5	43.7
DECEMBER	6.	80	8.4	8.4	52.2
JANUARY	7.	89	9.4	9.4	61.6
FEBRUARY	8.	66	7.0	7.0	68.5
MARCH	9.	84	8.9	8.9	77.4
APRIL	10.	69	7.3	7.3	84.7
MAY	11.	82	8.7	8.7	93.3
JUNE	12.	63	6.7	6.7	100.0
	TOTAL	947	100.0	100.0	

VALID CASES 947 MISSING CASES 0

FILE NONAME (CREATION DATE = 03/10/80)

FY 79

TYPE

CATEGORY LABEL	CODE	ABSOLUTE FREQ	RELATIVE FREQ (PCT)	ADJUSTED FREQ (PCT)	CUM FREQ (PCT)
VOLUNTARY	1.	201	21.2	21.2	21.2
JUDICIAL-PENDING JUD	2.	123	13.0	13.0	34.2
OBSERVE-EVALUATE	3.	238	25.1	25.1	59.3
CORRECTIONS TRANSFER	4.	70	7.4	7.4	66.7
M.D. CERTIFICATE	5.	225	23.8	23.8	90.5
TITLE 47 -- CIVIL	6.	10	1.1	1.1	91.6
TITLE 12 -- CRIMINAL	7.	14	1.5	1.5	93.0
INVOLUNTARY -- MINOR	8.	55	5.8	5.8	98.8
RETURN CONVALESCENT	9.	7	0.7	0.7	99.6
RETURN JUDICIAL	10.	1	0.1	0.1	99.7
UNKNOWN	12.	1	0.1	0.1	99.8
NOT STATED	13.	2	0.2	0.2	100.0
	TOTAL	947	100.0	100.0	

VALID CASES 947 MISSING CASES 0

FILE NONAME (CREATION DATE = 03/10/80)

ADMT FY 79

CATEGORY LABEL	CODE	ABSOLUTE FREQ	RELATIVE FREQ (PCT)	ADJUSTED FREQ (PCT)	CUM FREQ (PCT)
DAY	1.	384	40.5	40.5	40.5
NIGHT	2.	416	43.9	43.9	84.5
WEEKEND OR HOLIDAY	3.	146	15.4	15.4	99.9
NOT STATED	5.	1	0.1	0.1	100.0
	TOTAL	947	100.0	100.0	

VALID CASES 947 MISSING CASES 0

FILE NONAME (CREATION DATE = 03/10/80)

ADMW FY 79

CATEGORY LABEL	CODE	ABSOLUTE FREQ	RELATIVE FREQ (PCT)	ADJUSTED FREQ (PCT)	CUM FREQ (PCT)
WARD 1	1.	21	2.2	2.2	2.2
ADOLESCENT UNIT	2.	86	9.1	9.1	11.3
CHILDREN'S UNIT	3.	10	1.1	1.1	12.4
SCHRADER UNIT	4.	495	52.3	52.3	64.6
INTENSIVE TREAT UNIT	5.	2	0.2	0.2	64.8
PSYCH SECURITY UNIT	6.	331	35.0	35.0	99.8
NOT STATED	8.	2	0.2	0.2	100.0
	TOTAL	947	100.0	100.0	

VALID CASES 947 MISSING CASES 0

FILE NONAME (CREATION DATE = 03/10/80)

ADTYPE FY 79
PREVIOUS ADMISSION TYPE

CATEGORY LABEL	CODE	ABSOLUTE FREQ	RELATIVE FREQ (PCT)	ADJUSTED FREQ (PCT)	CUM FREQ (PCT)
VOLUNTARY	1.	140	14.8	14.8	14.8
JUDICIAL-PENDING JUD	2.	80	8.4	8.4	23.2
OBSERVE-EVALUATE	3.	83	8.8	8.8	32.0
CORRECTIONS TRANSFER	4.	43	4.5	4.5	36.5
M.D. CERTIFICATE	5.	120	12.7	12.7	49.2
TITLE 47 -- CIVIL	6.	5	0.5	0.5	49.7
TITLE 12 -- CRIMINAL	7.	2	0.2	0.2	49.9
INVOLUNTARY -- MINOR	8.	18	1.9	1.9	51.8
RETURN CONVALESCENT	9.	10	1.1	1.1	52.9
RETURN JUDICIAL	10.	2	0.2	0.2	53.1
NO PREVIOUS ADMIS	12.	443	46.8	46.8	99.9
UNKNOWN	13.	1	0.1	0.1	100.0
	TOTAL	947	100.0	100.0	

VALID CASES 947 MISSING CASES 0

TYPE OF ADMISSION

One-quarter of API admissions were a result of a physician's certificate. This occurs when a patient is not capable of signing a voluntary admission form, or is unwilling to do so, but the physician determines care is required.

Approximately one-fifth of the admissions to API in FY 78 were voluntary and another fifth of the admissions were for evaluation and observation.

Category Label	Absolute Frequency	Relative Frequency (PCT)
Return from Convalescent Leave	4	0.4
Evaluation and Observation	217	22.7
Title 47 (Civil)	13	1.4
Involuntary (Minor)	39	4.1
Judicial/Judicial Pending	122	12.7
Physician's Certificate	245	25.6
Return from Administrative Discharge Judicial	2	0.2
Voluntary	214	22.3
Title 12 (Criminal)	8	0.8
Correctional Transfer	84	8.8
Unknown	10	1.0
Total	958	100.0

Division of Mental Health & Developmental Disabilities
Mental Health Information System

Alaska Psychiatric Institute - Summary of Admissions and Discharges for FY77

Number of Admissions	801	
Number of Discharges	823	
Average Daily Census	113.5	(Range: 97-130)

ANALYSIS OF ADMISSIONS:

A. SEX:	Male	521	(65.0%)
	Female	280	(35.0%)

B. RACE:	Caucasian	510	(63.7%)
	Alaska Indian	62	(7.7%)
	Eskimo	135	(16.9%)
	Aleut	23	(2.9%)
	Black	36	(4.5%)
	Oriental (Asian)	8	(1.0%)
	Spanish-Am	7	(0.9%)
	Other	20	(2.5%)
	Not Indicated	0	(0.0%)

C. AGE:	Under 5	0	(0.0%)
	5-9	3	(0.4%)
	10-14	27	(3.4%)
	15-17	52	(6.5%)
	18-19	71	(8.9%)
	20-24	188	(23.5%)
	25-34	263	(32.8%)
	35-44	104	(2.9%)
	45-54	49	(6.1%)
	55-64	35	(4.4%)
	65 +	9	(1.1%)

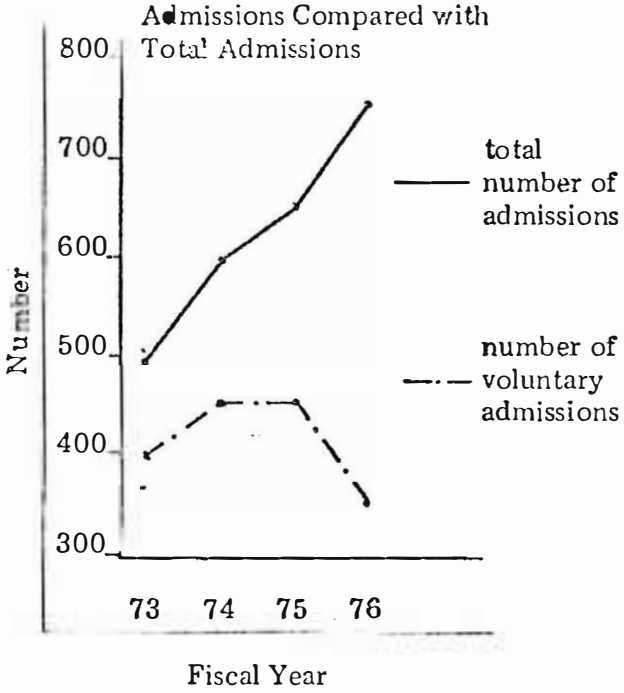
D. TYPE OF ADMISSION:	Voluntary	248	(31.0%)	
	Judicial/Judicial Pending	85	(10.6%)	
	Evaluation & Observation	157	(19.6%)	
	Correctional Transfer	72	(8.9%)	
	Physician's Certificate	239	(29.8%)	*

*Included in Judicial category in past years

Admissions by Type of Admission - As API responds to the demands placed upon it by the courts, the correctional system and various legal agencies, the number of voluntary admissions has actually decreased. Voluntary admissions account for less than half of the admissions. This increase represents an extra financial burden for the Division of Mental Health and Developmental Disabilities since for many of these admissions there is no reimbursement for services.

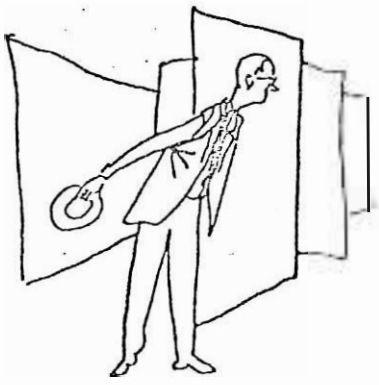
FY 73 - 76

Number of Voluntary Admissions Compared with Total Admissions



Type of Admission	FY73	FY74	FY75	FY76
Voluntary	399	456	466	353
Judicial	42	62	100	240
Evaluation & Observation	66	79	111	129
Correctional Transfer	---	---	---	17

Average Length of Stay - As a result of more intense treatment the average length of stay is decreasing. As treatment methods progress and community programs are strengthened, this should drop even more.



Average Length of Stay:

Fiscal Year	Number of Days
73	75.1
74	60.0
75	52.0
76	50.6

FILE NONAME (CREATION DATE = 03/10/80)

COMMUNITY MENTAL HEALTH CENTER

FY 79

REFER REFERRAL SOURCE

CATEGORY LABEL	CODE	ABSOLUTE FREQ	RELATIVE FREQ (PCT)	ADJUSTED FREQ (PCT)	CUM FREQ (PCT)
SELF	1.	1131	35.7	35.7	35.7
RELATIVES	10.	252	8.0	8.0	43.7
FRIENDS	11.	277	8.8	8.8	52.4
PUBLIC PSY HOSP	22.	103	3.3	3.3	55.7
CHILD RESOURCE	24.	1	0.0	0.0	55.7
PRIVATE MH PRO	31.	4	0.1	0.1	55.9
CMHC	32.	24	0.8	0.8	56.6
PRIVATE PHYS	41.	420	13.3	13.3	69.9
LOCAL HLTH DEPT	42.	20	0.6	0.6	70.5
GENERAL HOSP	43.	15	0.5	0.5	71.0
NURSING HOME	44.	30	0.9	0.9	71.9
INST MENT RET	45.	1	0.0	0.0	72.0
VA	47.	2	0.1	0.1	72.0
OTHER MED-HLTH	49.	16	0.5	0.5	72.5
SOC SERV AGNCY	60.	133	4.2	4.2	76.7
PHS	61.	54	1.7	1.7	78.5
COURT SYSTEM	70.	213	6.7	6.7	85.2
SCHOOL	80.	181	5.7	5.7	90.9
AK SKILLS CNTR	81.	15	0.5	0.5	91.4
CLERGY	91.	9	0.3	0.3	91.7
ALCOHOL RESOURCE	92.	5	0.2	0.2	91.8
VOC REHAB	93.	37	1.2	1.2	93.0

FILE NONAME (CREATION DATE = 03/10/80)

SENIOR CITIZEN	95.	12	0.4	0.4	93.4
EMPLOYER	96.	2	0.1	0.1	93.4
OTHER	99.	58	1.8	1.8	95.3
UNKNOWN	100.	150	4.7	4.7	100.0
	TOTAL	3165	100.0	100.0	

VALID CASES 3165 MISSING CASES 0

FILE NONAME (CREATION DATE = 03/10/80)

* * * * * * * * * * * * * * * * * * CROSSTABULATION OF * * * * * * * * * * * * * * * * * *
REFER REFERRAL SOURCE BY RACE
CONTROLLING FOR..
SEX VALUE = 1. MALE
* PAGE 1 OF 4

REFER	COUNT / ROW PCT / COL PCT	RACE 1. CAUCASIAN	2. INDIAN	3. ESKIMO	4. ALEUT	5. BLACK	6. ORIENTAL -ASIAN	7. SPANISH AMERICAN	8. OTHER	10. NOT STATED	ROW TOTAL
1. SELF		328	21	33	4	2	1	1	3	12	405
		81.0	5.2	8.1	1.0	0.5	0.2	0.2	0.7	3.0	29.9
		34.2	20.6	18.9	12.5	8.3	16.7	8.3	50.0	32.4	
10. RELATIVES		96	10	21	1	4	0	1	1	3	137
		70.1	7.3	15.3	0.7	2.9	0.0	0.7	0.7	2.2	10.1
		10.0	9.8	12.0	3.1	16.7	0.0	8.3	16.7	8.1	
11. FRIENDS		74	8	6	0	1	0	1	0	0	90
		82.2	8.9	6.7	0.0	1.1	0.0	1.1	0.0	0.0	6.6
		7.7	7.8	3.4	0.0	4.2	0.0	8.3	0.0	0.0	
22. PUBLIC PSY HOSP		38	2	2	3	6	0	1	0	3	55
		69.1	3.6	3.6	5.5	10.9	0.0	1.8	0.0	5.5	4.1
		4.0	2.0	1.1	9.4	25.0	0.0	8.3	0.0	8.1	
24. CHILD RESOURCE		0	0	0	1	0	0	0	0	0	1
		0.0	0.0	0.0	100.0	0.0	0.0	0.0	0.0	0.0	0.1
		0.0	0.0	0.0	3.1	0.0	0.0	0.0	0.0	0.0	
31. PRIVATE MH PRO		2	1	0	0	0	0	0	0	0	3
		66.7	33.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2
		0.2	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
32. CMHC		6	2	4	0	0	0	0	1	0	13
		46.2	15.4	30.8	0.0	0.0	0.0	0.0	7.7	0.0	1.0
		0.6	2.0	2.3	0.0	0.0	0.0	0.0	16.7	0.0	
41. PRIVATE PHYS		106	10	14	3	2	2	4	0	4	145
		73.1	6.9	9.7	2.1	1.4	1.4	2.8	0.0	2.8	10.7
		11.0	9.8	8.0	9.4	8.3	33.3	33.3	0.0	10.8	
COLUMN TOTAL		960	102	175	32	24	6	12	6	37	1354
		70.9	7.5	12.9	2.4	1.8	0.4	0.9	0.4	2.7	100.0

(CONTINUED)

FILE NONAME (CREATION DATE = 03/10/80)

* * * * * * * * * * * * * * * * * * C R O S S T A B U L A T I O N O F * * * * * * * * * * * * * * * * *
REFER REFERRAL SOURCE BY RACE
CONTROLLING FOR..
SEX VALUE = 1. MALE
* PAGE 2 OF 4

REFER (COUNT / ROW PCT / COL PCT)	CAUCASIAN 1.	INDIAN 2.	ESKIMO 3.	ALEUT 4.	BLACK 5.	ORIENTAL-ASIAN 6.	SPANISH AMERICAN 7.	OTHER 8.	NOT STATED 10.	ROW TOTAL
42. LOCAL HLTH DEPT	1	1	0	0	0	0	0	0	0	2
	50.0	50.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1
	0.1	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
43. GENERAL HOSP	3	1	1	0	0	1	0	0	0	6
	50.0	16.7	16.7	0.0	0.0	16.7	0.0	0.0	0.0	0.4
	0.3	1.0	0.6	0.0	0.0	16.7	0.0	0.0	0.0	
44. NURSING HOME	6	1	1	0	1	0	1	0	0	10
	60.0	10.0	10.0	0.0	10.0	0.0	10.0	0.0	0.0	0.7
	0.6	1.0	0.6	0.0	4.2	0.0	8.3	0.0	0.0	
47. VA	1	0	0	0	1	0	0	0	0	2
	50.0	0.0	0.0	0.0	50.0	0.0	0.0	0.0	0.0	0.1
	0.1	0.0	0.0	0.0	4.2	0.0	0.0	0.0	0.0	
49. OTHER MED-HLTH	3	0	0	1	0	0	0	0	0	4
	75.0	0.0	0.0	25.0	0.0	0.0	0.0	0.0	0.0	0.3
	0.3	0.0	0.0	3.1	0.0	0.0	0.0	0.0	0.0	
60. SOC SERV AGNCY	37	8	7	1	0	0	1	0	1	55
	67.3	14.5	12.7	1.8	0.0	0.0	1.8	0.0	1.8	4.1
	3.9	7.8	4.0	3.1	0.0	0.0	8.3	0.0	2.7	
61. PHS	8	2	11	1	0	0	0	0	0	22
	36.4	9.1	50.0	4.5	0.0	0.0	0.0	0.0	0.0	1.6
	0.8	2.0	6.3	3.1	0.0	0.0	0.0	0.0	0.0	
70. COURT SYSTEM	95	18	35	7	0	2	0	0	4	161
	59.0	11.2	21.7	4.3	0.0	1.2	0.0	0.0	2.5	11.9
	9.9	17.6	20.0	21.9	0.0	33.3	0.0	0.0	10.8	
COLUMN TOTAL	960	102	175	32	24	6	12	6	37	1354
	70.9	7.5	12.9	2.4	1.8	0.4	0.9	0.4	2.7	100.0

(CONTINUED)

* * * * * * * * * * * * * * * * * * C R O S S T A B U L A T I O N O F * * * * * * * * * * * * * * * * * *
REFER REFERRAL SOURCE BY RACE
CONTROLLING FOR..
SEX VALUE = 1. MALE
* PAGE 3 OF 4

REFER	RACE: COUNT / ROW PCT / COL PCT	CAUCASIAN 1.	INDIAN 2.	ESKIMO 3.	ALEUT 4.	BLACK 5.	ORIENTAL -ASIAN 6.	SPANISH AMERICAN 7.	OTHER 8.	NOT STATED 10.	ROW TOTAL
80. SCHOOL	COUNT	88	5	8	4	3	0	0	0	5	113
	ROW PCT	77.9	4.4	7.1	3.5	2.7	0.0	0.0	0.0	4.4	8.3
	COL PCT	9.2	4.9	4.6	12.5	12.5	0.0	0.0	0.0	13.5	
81. AK SKILLS CNTR	COUNT	4	1	5	0	0	0	0	0	0	10
	ROW PCT	40.0	10.0	50.0	0.0	0.0	0.0	0.0	0.0	0.0	0.7
	COL PCT	0.4	1.0	2.9	0.0	0.0	0.0	0.0	0.0	0.0	
91. CLERGY	COUNT	3	0	0	0	0	0	0	0	0	3
	ROW PCT	100.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2
	COL PCT	0.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
92. ALCOHOL RESOURCE	COUNT	2	0	0	1	0	0	0	0	0	3
	ROW PCT	66.7	0.0	0.0	33.3	0.0	0.0	0.0	0.0	0.0	0.2
	COL PCT	0.2	0.0	0.0	3.1	0.0	0.0	0.0	0.0	0.0	
93. VOC REHAB	COUNT	12	1	2	0	2	0	1	0	0	18
	ROW PCT	66.7	5.6	11.1	0.0	11.1	0.0	5.6	0.0	0.0	1.3
	COL PCT	1.3	1.0	1.1	0.0	8.3	0.0	8.3	0.0	0.0	
95. SENIOR CITIZEN	COUNT	3	0	0	0	0	0	0	0	0	3
	ROW PCT	100.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2
	COL PCT	0.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
96. EMPLOYER	COUNT	1	0	0	0	0	0	0	0	0	1
	ROW PCT	100.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1
	COL PCT	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
99. OTHER	COUNT	12	3	4	2	0	0	0	0	2	23
	ROW PCT	52.2	13.0	17.4	8.7	0.0	0.0	0.0	0.0	8.7	1.7
	COL PCT	1.3	2.9	2.3	6.3	0.0	0.0	0.0	0.0	5.4	
COLUMN TOTAL		960	102	175	32	24	6	12	6	37	1354
		70.9	7.5	12.9	2.4	1.8	0.4	0.9	0.4	2.7	100.0

(CONTINUED)

FILE NONAME (CREATION DATE = 03/10/80)

* * * * * * * * * * * * * * * * * * C R O S S T A B U L A T I O N O F * * * * * * * * * * * * * * * *
REFER REFERRAL SOURCE BY RACE
CONTROLLING FOR..
SEX VALUE = 1. MALE
* PAGE 4 OF 4

REFER	RACE COUNT ROW PCT COL PCT	CAUCASIAN 1.	INDIAN 2.	ESKIMO 3.	ALEUT 4.	BLACK 5.	ORIENTAL-ASIAN 6.	SPANISH AMERICAN 7.	OTHER 8.	NOT STATED 10.	ROW TOTAL
UNKNOWN	100.	31 44.9 3.2	7 10.1 6.9	21 30.4 12.0	3 4.3 9.4	2 2.9 8.3	0 0.0 0.0	1 1.4 8.3	1 1.4 16.7	3 4.3 8.1	69 5.1
	COLUMN TOTAL	960 70.9	102 7.5	175 12.9	32 2.4	24 1.8	6 0.4	12 0.9	6 0.4	37 2.7	1354 100.0

FILE NONAME (CREATION DATE = 03/10/80)

* * * * * * * * * * * * * * * * * * C R O S S T A B U L A T I O N O F * * * * * * * * * * * * * * * * *
REFER REFERRAL SOURCE BY RACE
CONTROLLING FOR..
SEX VALUE = 2. FEMALE
* PAGE 1 OF 3

REFER	RACE: COUNT / ROW PCT / COL PCT	CAUCASIAN 1.	INDIAN 2.	ESKIMO 3.	ALEUT 4.	BLACK 5.	ORIENTAL-ASIAN 6.	SPANISH AMERICAN 7.	OTHER 8.	NOT STATED 10.	ROW TOTAL
1. SELF	COUNT	579	53	42	11	6	5	6	3	10	715
	ROW PCT	81.0	7.4	5.9	1.5	0.8	0.7	0.8	0.4	1.4	40.2
	COL PCT	43.2	37.3	24.6	23.9	23.1	45.5	40.0	37.5	45.5	
10. RELATIVES	COUNT	91	9	6	0	2	0	0	1	2	111
	ROW PCT	82.0	8.1	5.4	0.0	1.8	0.0	0.0	0.9	1.8	6.2
	COL PCT	6.8	6.3	3.5	0.0	7.7	0.0	0.0	12.5	9.1	
11. FRIENDS	COUNT	152	9	11	7	1	1	0	1	4	186
	ROW PCT	81.7	4.8	5.9	3.8	0.5	0.5	0.0	0.5	2.2	10.4
	COL PCT	11.4	6.3	6.4	15.2	3.8	9.1	0.0	12.5	13.2	
22. PUBLIC PSY HOSP	COUNT	32	4	5	2	2	0	0	0	2	47
	ROW PCT	68.1	8.5	10.6	4.3	4.3	0.0	0.0	0.0	4.3	2.6
	COL PCT	2.4	2.8	2.9	4.3	7.7	0.0	0.0	0.0	9.1	
31. PRIVATE MH PRO	COUNT	1	0	0	0	0	0	0	0	0	1
	ROW PCT	100.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1
	COL PCT	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
32. CMHC	COUNT	4	1	4	0	1	0	0	1	0	11
	ROW PCT	36.4	9.1	36.4	0.0	9.1	0.0	0.0	9.1	0.0	0.6
	COL PCT	0.3	0.7	2.3	0.0	3.8	0.0	0.0	12.5	0.0	
41. PRIVATE PHYS	COUNT	214	22	16	12	5	1	4	0	0	274
	ROW PCT	78.1	8.0	5.8	4.4	1.8	0.4	1.5	0.0	0.0	15.4
	COL PCT	16.0	15.5	9.4	26.1	19.2	9.1	26.7	0.0	0.0	
42. LOCAL HLTH DEPT	COUNT	5	11	1	0	0	0	1	0	0	18
	ROW PCT	27.8	61.1	5.6	0.0	0.0	0.0	5.6	0.0	0.0	1.0
	COL PCT	0.4	7.7	0.6	0.0	0.0	0.0	6.7	0.0	0.0	
COLUMN TOTAL		1339	142	171	46	26	11	15	8	22	1780
		75.2	8.0	9.6	2.6	1.5	0.6	0.8	0.4	1.2	100.0

(CONTINUED)

FILE NONAME (CREATION DATE = 03/10/80)

* * * * * * * * * * * * * * * * * * C R O S S T A B U L A T I O N O F * * * * * * * * * * * * * * * * * *
REFER REFERRAL SOURCE BY RACE
CONTROLLING FOR..
SEX VALUE = 2. FEMALE
* PAGE 2 OF 3

REFER	RACE: COUNT / ROW PCT / COL PCT	CAUCASIAN 1.	INDIAN 2.	ESKIMO 3.	ALEUT 4.	BLACK 5.	ORIENTAL-ASIAN 6.	SPANISH AMERICAN 7.	OTHER 8.	NOT STATED 10.	ROW TOTAL
43. GENERAL HOSP	COUNT	3	1	4	1	0	0	0	0	0	9
	ROW PCT	33.3	11.1	44.4	11.1	0.0	0.0	0.0	0.0	0.0	0.5
	COL PCT	0.2	0.7	2.3	2.2	0.0	0.0	0.0	0.0	0.0	
44. NURSING HOME	COUNT	16	1	2	0	1	0	0	0	0	20
	ROW PCT	80.0	5.0	10.0	0.0	5.0	0.0	0.0	0.0	0.0	1.1
	COL PCT	1.2	0.7	1.2	0.0	3.8	0.0	0.0	0.0	0.0	
45. INST MENT RET	COUNT	0	0	0	0	0	0	0	0	1	1
	ROW PCT	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100.0	0.1
	COL PCT	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	4.5	
49. OTHER MED-HLTH	COUNT	3	5	4	0	0	0	0	0	0	12
	ROW PCT	25.0	41.7	33.3	0.0	0.0	0.0	0.0	0.0	0.0	0.7
	COL PCT	0.2	3.5	2.3	0.0	0.0	0.0	0.0	0.0	0.0	
60. SOC SERV AGNCY	COUNT	51	4	11	4	2	3	0	2	0	77
	ROW PCT	66.2	5.2	14.3	5.2	2.6	3.9	0.0	2.6	0.0	4.3
	COL PCT	3.8	2.8	6.4	8.7	7.7	27.3	0.0	25.0	0.0	
61. PHS	COUNT	12	9	7	0	1	0	0	0	2	31
	ROW PCT	38.7	29.0	22.6	0.0	3.2	0.0	0.0	0.0	6.5	1.7
	COL PCT	0.9	6.3	4.1	0.0	3.8	0.0	0.0	0.0	9.1	
70. COURT SYSTEM	COUNT	30	3	17	1	0	0	0	0	0	51
	ROW PCT	58.8	5.9	33.3	2.0	0.0	0.0	0.0	0.0	0.0	2.9
	COL PCT	2.2	2.1	9.9	2.2	0.0	0.0	0.0	0.0	0.0	
80. SCHOOL	COUNT	49	3	5	4	3	0	1	0	0	65
	ROW PCT	75.4	4.6	7.7	6.2	4.6	0.0	1.5	0.0	0.0	3.7
	COL PCT	3.7	2.1	2.9	8.7	11.5	0.0	6.7	0.0	0.0	
COLUMN TOTAL		1339	142	171	46	26	11	15	8	22	1780
		75.2	8.0	9.6	2.6	1.5	0.6	0.8	0.4	1.2	100.0

(CONTINUED)

FILE NONAME (CREATION DATE = 03/10/80)

* * * * * * * * * * * * * * * * * * C R O S S T A B U L A T I O N O F * * * * * * * * * * * * * * * * * *
REFER REFERRAL SOURCE BY RACE
CONTROLLING FOR..
SEX VALUE = 2. FEMALE
* PAGE 3 OF 3

REFER	COUNT / ROW PCT / COL PCT	CAUCASIAN 1.	INDIAN 2.	ESKIMO 3.	ALEUT 4.	BLACK 5.	ORIENTAL-ASIAN 6.	SPANISH AMERICAN 7.	OTHER 8.	NOT STATED 10.	ROW TOTAL
81.	COUNT	3	0	1	1	0	0	0	0	0	5
AK SKILLS CNTR	ROW PCT	60.0	0.0	20.0	20.0	0.0	0.0	0.0	0.0	0.0	0.3
	COL PCT	0.2	0.0	0.6	2.2	0.0	0.0	0.0	0.0	0.0	
91.	COUNT	5	0	0	0	0	0	0	0	0	5
CLERGY	ROW PCT	100.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.3
	COL PCT	0.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
92.	COUNT	0	0	1	1	0	0	0	0	0	2
ALCOHOL RESOURCE	ROW PCT	0.0	0.0	50.0	50.0	0.0	0.0	0.0	0.0	0.0	0.1
	COL PCT	0.0	0.0	0.6	2.2	0.0	0.0	0.0	0.0	0.0	
93.	COUNT	14	3	2	0	0	0	0	0	0	19
VOC REHAB	ROW PCT	73.7	15.8	10.5	0.0	0.0	0.0	0.0	0.0	0.0	1.1
	COL PCT	1.0	2.1	1.2	0.0	0.0	0.0	0.0	0.0	0.0	
95.	COUNT	6	0	0	0	0	0	0	0	1	7
SENIOR CITIZEN	ROW PCT	85.7	0.0	0.0	0.0	0.0	0.0	0.0	0.0	14.3	0.4
	COL PCT	0.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	4.5	
96.	COUNT	1	0	0	0	0	0	0	0	0	1
EMPLOYER	ROW PCT	100.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1
	COL PCT	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
99.	COUNT	26	1	4	0	0	0	3	0	0	34
OTHER	ROW PCT	76.5	2.9	11.8	0.0	0.0	0.0	8.8	0.0	0.0	1.9
	COL PCT	1.9	0.7	2.3	0.0	0.0	0.0	20.0	0.0	0.0	
100.	COUNT	42	3	28	2	2	1	0	0	0	78
UNKNOWN	ROW PCT	53.8	3.8	35.9	2.6	2.6	1.3	0.0	0.0	0.0	4.4
	COL PCT	3.1	2.1	16.4	4.3	7.7	9.1	0.0	0.0	0.0	
COLUMN	TOTAL	1339	142	171	46	26	11	15	8	22	1780
		75.2	8.0	9.6	2.6	1.5	0.6	0.8	0.4	1.2	100.0

FILE NONAME (CREATION DATE = 03/10/80)

* * * * * * * * * * * * * * * * * * C R O S S T A B U L A T I O N O F * * * * * * * * * * * * * * * * * *
REFER REFERRAL SOURCE BY RACE
CONTROLLING FOR..
SEX VALUE = 4. NOT STATED
* PAGE 1 OF 2

REFER	COUNT / ROW PCT / COL PCT	RACE: CAUCASIAN 1.	INDIAN 2.	ESKIMO 3.	NOT STATED 10.	ROW TOTAL
SELF	1.	4	1	4	2	11
		36.4	9.1	36.4	18.2	35.5
		36.4	50.0	33.3	33.3	
RELATIVES	10.	2	1	0	1	4
		50.0	25.0	0.0	25.0	12.9
		18.2	50.0	0.0	16.7	
FRIENDS	11.	1	0	0	0	1
		100.0	0.0	0.0	0.0	3.2
		9.1	0.0	0.0	0.0	
PUBLIC PSY HOSP	22.	0	0	0	1	1
		0.0	0.0	0.0	100.0	3.2
		0.0	0.0	0.0	16.7	
PRIVATE PHYS	41.	0	0	0	1	1
		0.0	0.0	0.0	100.0	3.2
		0.0	0.0	0.0	16.7	
SOC SERV AGNCY	60.	0	0	1	0	1
		0.0	0.0	100.0	0.0	3.2
		0.0	0.0	8.3	0.0	
PHS	61.	0	0	1	0	1
		0.0	0.0	100.0	0.0	3.2
		0.0	0.0	8.3	0.0	
COURT SYSTEM	70.	1	0	0	0	1
		100.0	0.0	0.0	0.0	3.2
		9.1	0.0	0.0	0.0	
	COLUMN TOTAL	11	2	12	6	31
		35.5	6.5	38.7	19.4	100.0

(CONTINUED)

FILE NONAME (CREATION DATE = 03/10/80)

* * * * * * * * * * * * * * * * * * C R O S S T A B U L A T I O N O F * * * * * * * * * * * * * * * * * *
REFER REFERRAL SOURCE BY RACE
CONTROLLING FOR..
SEX VALUE = 4. NOT STATED
* PAGE 2 OF 2

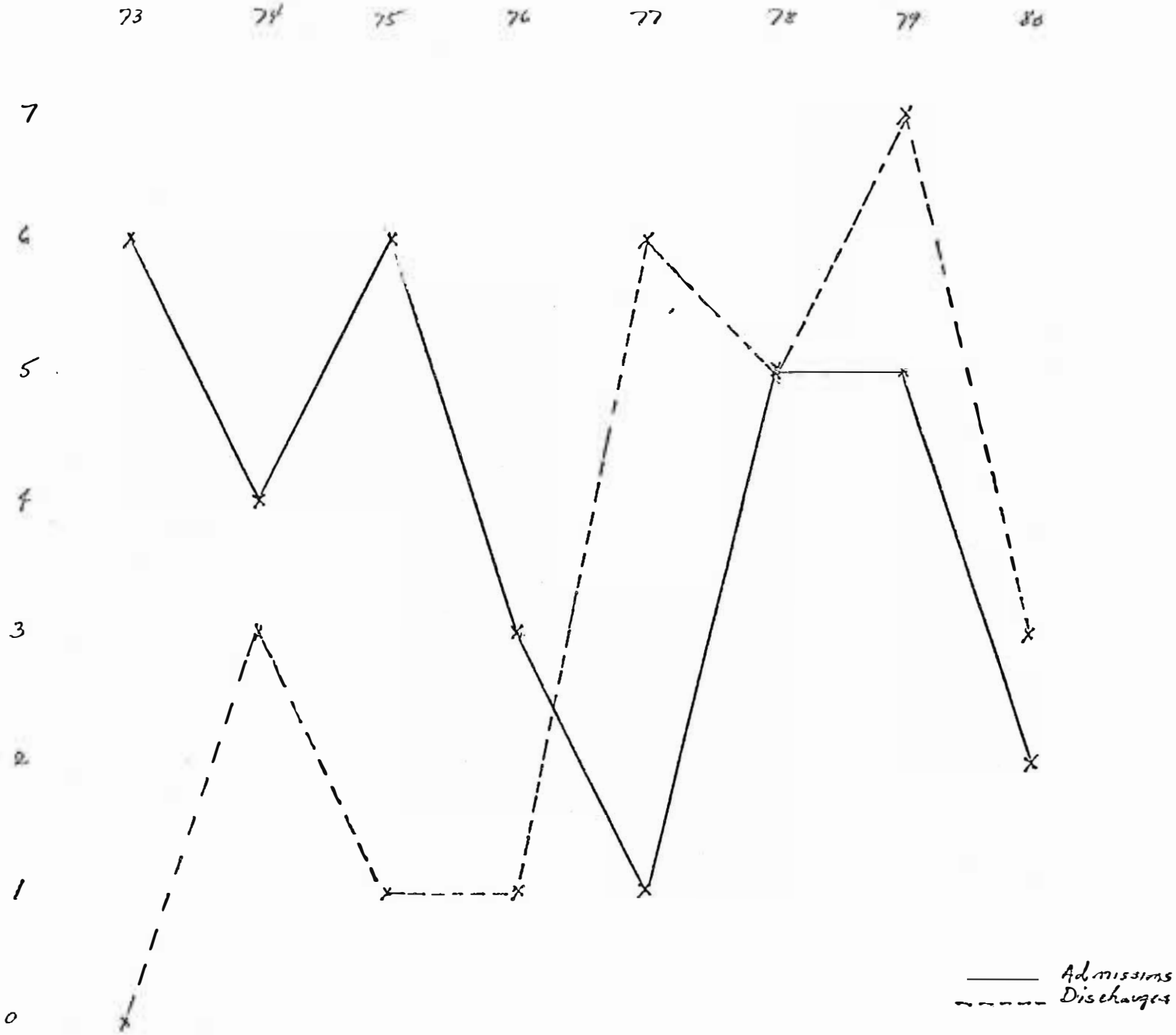
REFER	COUNT / ROW PCT / COL PCT	RACE: CAUCASIAN 1.	INDIAN 2.	ESKIMO 3.	NOT STATED 10.	ROW TOTAL
SCHOOL	80.	0 0.0 0.0	0 0.0 0.0	3 100.0 25.0	0 0.0 0.0	3 9.7
CLERGY	91.	1 100.0 9.1	0 0.0 0.0	0 0.0 0.0	0 0.0 0.0	1 3.2
SENIOR CITIZEN	95.	2 100.0 18.2	0 0.0 0.0	0 0.0 0.0	0 0.0 0.0	2 6.5
OTHER	99.	0 0.0 0.0	0 0.0 0.0	0 0.0 0.0	1 100.0 16.7	1 3.2
UNKNOWN	100.	0 0.0 0.0	0 0.0 0.0	3 100.0 25.0	0 0.0 0.0	3 9.7
	COLUMN TOTAL	11 35.5	2 6.5	12 38.7	6 19.4	31 100.0

ATASCADERO STATE HOSPITAL

Summary of Admissions and Discharges
Fiscal Year 1973 - 1980

Fiscal Year	Admissions	Discharges
1973	6	0
1974	4	3
1975	6	1
1976	3	1
1977	1	6
1978	5	5
1979	5	7
1980	2	3
	32	26

DISCHARGES AND ADMISSIONS TO ATASCADERO



APPENDIX D

Alaska Mental Status Statutes

Sec. 12.45.083. Mental disease or defect excluding responsibility. (a) A person is not responsible for criminal conduct if at the time

of the conduct, as a result of mental disease or defect, he lacks substantial capacity either to appreciate the wrongfulness of his conduct or to conform his conduct to the requirements of law.

(b) Reliance on mental disease or defect as excluding responsibility is an affirmative defense. The burden of proof beyond a reasonable doubt does not require the prosecution to disprove an affirmative defense unless and until there is evidence supporting the defense. The requirement of evidence supporting the affirmative defense is not satisfied solely by evidence of an abnormality which is manifested only by repeated criminal or otherwise antisocial conduct.

(c) If the defendant is acquitted on the ground of mental disease or defect excluding responsibility, the verdict and the judgment shall so state.

(d) When a person offers a defense based on mental disease or defect excluding responsibility for his criminal conduct, he may waive a jury trial without the consent of the state. (§ 1 ch 119 SLA 1972)

Revisor's note (1972). — AS 12.45.083, 12.45.085, 12.45.087, and 12.45.100(a) are based on provisions in Article 4 of the Model Penal Code of the American Law Institute.

Editor's note. — Section 7, ch. 119, SLA 1972, provides: "In sec. 1 of this Act, AS 12.45.085 has the effect of changing Rule 12(b), Rules of Criminal Procedure, in that it adds to the defenses which must be raised before trial, and AS 12.45.083(d) changes Rule 23(a) of the Rules of Criminal Procedure in that the defendant may, without the consent of the state, waive a jury trial if his defense is based on mental disease or defect excluding responsibility."

Sec. 12.45.085. Evidence of mental disease or defect. Evidence that the defendant suffered from a mental disease or defect is admissible whenever it is relevant to prove that the defendant did or did not have a state of mind which is an element of the offense. However, evidence of mental disease or defect excluding responsibility is not admissible unless the defendant, at the time of entering his plea of not guilty or within 10 days thereafter or at such later time as the court may for good cause permit, files a written notice of his intent to rely on that defense. (§ 1 ch 119 SLA 1972)

Editor's note.—Section 7, ch. 119, SLA 1972, provides: "In sec. 1 of this Act, AS 12.45.085 has the effect of changing Rule 12(b), Rules of Criminal Procedure, in that it adds to the defenses which must be raised before trial, and AS 12.45.083(d) changes Rule 23(a) of the Rules of Criminal Procedure in that the defendant may, without the consent of the state, waive a jury trial if his defense is based on mental disease or defect excluding responsibility."

Sec. 12.45.087. Psychiatric examination. (a) If a defendant has filed a notice of intention to rely on the defense of mental disease or defect excluding responsibility, or there is reason to doubt his fitness to proceed, or there is reason to believe that mental disease or defect of the defendant will otherwise become an issue in the

cause, the court shall appoint at least one qualified psychiatrist or shall request the superintendent of the Alaska Psychiatric Institute to designate at least one qualified psychiatrist, which designation may be or include himself, to examine and report upon the mental condition of the defendant. The court may order the defendant to be committed to a hospital or other suitable facility for the purpose of the examination for not more than 60 days or such longer period as the court determines to be necessary for the purpose and may direct that a qualified psychiatrist retained by the defendant be permitted to witness and participate in the examination.

(b) In an examination under (a) of this section, any method may be employed which is accepted by the medical profession for the examination of those alleged to be suffering from mental disease or defect.

(c) The report of an examination under (a) of this section shall include the following:

(1) a description of the nature of the examination;

(2) a diagnosis of the mental condition of the defendant;

(3) if the defendant suffers from a mental disease or defect, an opinion as to his capacity to understand the proceedings against him and to assist in his own defense;

(4) if a notice of intention to rely on the defense of irresponsibility has been filed, an opinion as to the extent, if any, to which the capacity of the defendant to appreciate the wrongfulness of his conduct or to conform his conduct to the requirements of law was impaired at the time of the criminal conduct charged; and

(5) if directed by the court, an opinion as to the capacity of the defendant to have a particular state of mind which is an element of the offense charged.

(d) If the examination under (a) of this section cannot be conducted by reason of the unwillingness of the defendant to participate in it, the report shall so state and shall include, if possible, an opinion as to whether the unwillingness of the defendant was the result of mental disease or defect.

(e) The report of the examination under (a) of this section shall be filed with the clerk of the court, who shall cause copies to be delivered to the district attorney and to counsel for the defendant. (§ 1 ch 119 SLA 1972)

Sec. 12.45.090. Commitment after judgment of not guilty. If the jury finds the defendant not guilty on the ground of mental disease or defect and the court considers his being at large dangerous to the public peace or safety, the court shall order him to be committed to an institution authorized by the commissioner of health

and social services to receive that person, and held in custody until the disease is cured or the defect corrected or he is otherwise discharged from the institution by authority of law. (§ 6.10 ch 34 SLA 1962; am § 6 ch 104 SLA 1971; am § 2 ch 119 SLA 1972)

Effect of amendments. — The 1971 amendment substituted "commissioner of health and social services" for "commissioner of health and welfare."

The 1972 amendment substituted "mental disease or defect" for "insanity," substituted "the disease is cured or the defect corrected" for "he becomes sane," inserted "he" preceding "is otherwise discharged," and substituted "from the institution" for "therefrom."

Am. Jur., ALR and C.J.S. references.—14 Am. Jur., Criminal Law, §§ 32 to 47; 28 Am. Jur., Insane and Other Incompetent Persons, § 1 et seq.; 53 Am. Jur., Trial, §§ 47 to 52.

Test of present insanity which will prevent trial for crime or punishment after conviction, 3 ALR 94.

Remedy of one convicted of crime while insane, 10 ALR 213; 121 ALR 267.

Constitutionality of statutes relating to determination of plea of insanity in criminal case, 67 ALR 1451.

Manner of raising question of present insanity precluding trial of accused, 142 ALR 976.

22 C.J.S. Criminal Law §§ 56 to 64, 170; 23 C.J.S. Criminal Law § 940.

Sec. 12.45.100. Determination of mental disease or defect during trial or probation. (a) No person who as a result of mental disease or defect lacks capacity to understand the proceedings against him or to assist in his own defense may be tried, convicted or sentenced for the commission of an offense so long as the incapacity endures.

(b) When, after arrest and before the imposition of sentence or before the expiration of any period of probation, the attorney general, the district attorney, or the attorney for the accused has reasonable cause to believe that a person charged with an offense may be presently suffering mental disease or defect or is otherwise so mentally incompetent that he is unable to understand the proceedings against him or properly to assist in his own defense, he may file a motion for a judicial determination of the mental competency of the accused. Upon that motion or upon a similar motion in behalf of the accused, or upon its own motion, the court shall have the accused, whether or not previously admitted to bail, examined as to his mental condition by at least one qualified psychiatrist, who shall report to the court. For the purpose of the examination the court may be submitted, including that of the reporting psychiatrist, and court may determine to a suitable hospital or other facility to be designated by the court. If the report of the psychiatrist indicates a state of present mental disease or defect or of other mental incompetency in the accused, the court shall hold a hearing, upon due notice, at which evidence as to the mental condition of the accused may be submitted, including that of the reporting psychiatrist, and make a finding with respect to his mental condition. No statement made by the accused in the course of an examination into his mental competency provided for by this section, whether the examina-

tion is with or without the consent of the accused, may be admitted in evidence against the accused on the issue of guilt in a criminal proceeding. A finding by the judge that the accused is mentally competent to stand trial in no way prejudices the accused in a defense based on mental disease or defect excluding responsibility; the finding may not be introduced in evidence on that issue or otherwise be brought to the notice of the jury. (§ 6.11 ch 34 SLA 1962; am § 3 ch 119 SLA 1972)

Effect of amendment. — The 1972 amendment designated the former section as subsection (b) and added subsection (a). In subsection (b), the amendment substituted "suffering mental disease or defect" for "insane" in the first sentence, inserted "is" preceding "otherwise so mentally incompetent" in that sentence, substituted "mental disease or defect" for "insanity" in the fourth sentence, inserted "other" preceding "mental incompetency" in that sentence, deleted "sanity or" preceding "mental competency" in the fifth sentence, and substituted "defense based on mental disease or defect excluding responsibility" for "plea of insanity as a defense to the crime charged" in the sixth sentence.

Common law.—It was the rule at common law that an accused should not be subjected to a criminal trial if he is in such a mental condition that he is unable to understand the proceedings against him or to properly assist in his own defense. Bosel v. State, Sup. Ct. Op. No. 280 (File No. 32). 398 P.2d 651 (1965).

This section is patterned after 18 U.S.C. § 4244. Bosel v. State, Sup. Ct. Op. No 280 (File No. 32), 398 P.2d 651 (1965).

This section is clear enough. Thessen v. State, Sup. Ct. Op. No. 555 (File No. 898), 454 P.2d 341 (1969).

ALR reference. — Investigation of present insanity to determine whether accused should be put, or continued, on trial, 142 ALR 961.

Sec. 12.45.110. Commitment on finding of insanity. (a) When the trial court determines, in accordance with § 100 of this chapter, that an accused is or was so mentally incompetent that he is unable to understand the proceedings against him or properly to assist in his own defense, the court may commit the accused to the custody of the commissioner of health and social services or his authorized representative until the accused is mentally competent to stand trial, or until the pending charges against him are disposed of according to law. The accused is not subject to expenses of hospitalization and transportation incurred as a result of his commitment under this section and the liability for payment in AS 47.30.270 does not apply to commitments under this section.

(b) The committing court in its commitment order shall require the commissioner or his authorized representative to submit periodic written reports upon the mental condition of an accused person who is committed under (a) of this section. (§ 6.12 ch 34 SLA 1962; am § 1 ch 43 SLA 1966; am § 6 ch 104 SLA 1971)

Effect of amendments. — The 1966 amendment designated the former section as subsection (a), added the last sentence of such subsection, and added subsection (b).

The 1971 amendment substituted "commissioner of health and social services" for "commissioner of health and welfare" in the first sentence of subsection (a).

A defendant committed pursuant to this section is still charged with a crime. 1963 Op. Att'y Gen., No. 21.

And only the determination of his guilt or innocence is postponed until he is competent to stand trial. 1963 Op. Att'y Gen., No. 21.

Property of accused.—Commitment pursuant to this section does not deprive an accused of the management of his property nor make the commissioner of health and social services the guardian of the accused's property. 1963 Op. Att'y Gen., No. 21.

The commissioner of health and social services is not responsible for the property of one charged with a crime who has been determined to be insane or mentally incompetent before trial. 1963 Op. Att'y Gen., No. 21.

Procedures under this section and AS 20.05.090 distinguished. — While the procedure in this section is available in any trial court, the proceeding outlined in AS 20.05.090 can only be performed in the superior court. 1963 Op. Att'y Gen., No. 21.

Commitment of an insane person pursuant to this section is a separate proceeding from the appointment of a guardian of an insane person under AS 20.05.090. 1963 Op. Att'y Gen., No. 21.

C.J.S. references.—22 C.J.S. Criminal Law § 170; 23 C.J.S. Criminal Law § 940.

Sec. 12.45.115. Determination of sanity after release from commitment. (a) When, in the medical judgment of the custodian of an accused person committed under § 110(a) of this chapter, the accused is considered to be mentally competent to stand trial, the committing court shall hold a hearing, after due notice, as soon as conveniently possible after release of the accused from custody. At the hearing, evidence as to the mental condition of the accused may be submitted including reports by the custodian to whom the accused was committed for care.

(b) If at the hearing the court determines that the accused is presently mentally competent to understand the nature of the proceedings against him or to assist in his own defense, appropriate criminal proceedings shall be commenced against the accused.

(c) If at the hearing the court determines that the accused is still presently mentally incompetent, the court shall recommit the accused as provided in § 110(a) of this chapter.

(d) A finding by the court that the accused is mentally competent to stand trial in no way prejudices the accused in a defense based on mental disease or defect excluding responsibility. This finding may not be introduced in evidence on that issue or otherwise be brought to the notice of the jury. (§ 2 ch 43 SLA 1966; am §§ 4—6 ch 119 SLA 1972)

Effect of amendment. — The 1972 amendment deleted "sane or" preceding "mentally competent" in subsection (b), deleted "insane or" preceding "mentally incompetent" in subsection (c), and substituted "defense based on mental disease or defect excluding responsibility" for "plea of insanity as a defense to the crime charged" in the first sentence of subsection (d).

Sec. 12.45.083. Mental disease or defect excluding responsibility.

This section was not made retroactive. — Johnson v. State, Sup. Ct. Op. No. 888 (File No. 1477), 511 P.2d 118 (1973).

The test under this section must be used after September 10, 1972, its effective date. Schade v. State, Sup. Ct. Op. No. 912 (File No. 1620), 512 P.2d 907 (1973).

There is nothing in the language of this section to suggest that the legislature intended it to operate retroactively.

Morgan v. State, Sup. Ct. Op. No. 913 (File No. 1527), 512 P.2d 904 (1973).

Distinction between defense of mental disease or defect and doctrine of diminished capacity. — The supreme court has drawn a distinction between the defense of mental disease or defect, which absolves a defendant from criminal responsibility for any type of crime, and the doctrine of diminished capacity, which acts only to negate a specific mental element or intent necessary to the charged offense. Mill v. State, Sup. Ct. Op. No. 1751 (File No. 2692), 585 P.2d 546 (1978).

Where the accused is substantially unable to control his behavior and conform it to the requirements of the law, he fits within the framework of the defense of mental disease or defect and need not rely on diminished capacity. Mill v. State, Sup. Ct. Op. No. 1751 (File No. 2692), 585 P.2d 546 (1978).

A defendant whose mental capacities have been diminished may not possess a certain specific mental state or intent essential to the crime, but the doctrine of diminished capacity due to a mental illness or defect is not available to show lack of general intent to do an act, or it would have the same function as the defense of mental disease or defect. Mill v. State, Sup. Ct. Op. No. 1751 (File No. 2692), 585 P.2d 546 (1978).

Diminished capacity cannot be invoked to negate general criminal intent. — There appears to be no jurisdiction in which diminished capacity can be invoked to negate general criminal intent by a defendant who does not plead mental disease or defect as a defense. Mill v. State, Sup. Ct. Op. No. 1751 (File No. 2692), 585 P.2d 546 (1978).

This section defines an insanity test patterned on § 4.01 of the Model Penal Code. Morgan v. State, Sup. Ct. Op. No. 913 (File No. 1527), 512 P.2d 904 (1973).

The test of criminal responsibility under this section is almost identical to the one developed by the American Law Institute (ALI). Alto v. State, Sup. Ct. Op. No. 1443 (File No. 2339), 565 P.2d 492 (1977).

This section is modeled on the American Law Institute's substantial capacity test. McKinney v. State, Sup. Ct. Op. No. 1451 (File No. 2758), 566 P.2d 653, remanded on rehearing on other grounds, 570 P.2d 733 (1977).

The provisions of this section were adopted by the legislature in 1972 based on sections contained in article IV of the Model Penal Code of the American Law Institute. State v. Alto, Sup. Ct. Op. No. 1777 (File No. 3748), 589 P.2d 402 (1979).

This test differs in only one minor particular from the Model Penal Code formulation: The latter test excludes from the term "mental disease or defect" an abnormality manifested only by repeated criminal or antisocial conduct, but this section says that the burden of proof of insanity as an affirmative defense is not satisfied solely by evidence of such abnormality. Schade v. State, Sup. Ct. Op. No. 912 (File No. 1620), 512 P.2d 907 (1973).

Legal insanity couched in terms of responsibility. — Legal insanity, as a defense to the commission of a crime, is couched in terms of lack of responsibility for criminal conduct as a result of a mental disease or defect. Dolchok v. State, Sup. Ct. Op. No. 1006 (File No. 1828), 519 P.2d 457 (1974).

When person insane in legal sense. — A person is insane in the legal sense, and not responsible, only if at the time of his antisocial conduct, as a result of mental disease or defect, he lacks substantial capacity either to appreciate the wrongfulness of his conduct or to conform his conduct to the requirements of law. Bordewick v. State, Sup. Ct. Op. No. 1500 (File No. 3341), 569 P.2d 184 (1977).

Insanity test must be that set forth in subsection (a). Kinsman v. State, Sup. Ct. Op. No. 914 (File No. 1508), 512 P.2d 901 (1973).

Such test is the correct one. — The test currently found in this section, which encapsulates the American Law Institute formulation, is the correct one and should have been employed in cases tried prior to the effective date of this section. Schade v. State, Sup. Ct. Op. No. 912 (File No. 1620), 512 P.2d 907 (1973).

The M'Naghten test is no longer acceptable. Schade v. State, Sup. Ct. Op. No. 912 (File No. 1620), 512 P.2d 907 (1973).

For discussion of defects of M'Naghten rule, see Schade v. State, Sup. Ct. Op. No. 912 (File No. 1620), 512 P.2d 907 (1973).

This section does not speak to the role of voluntary intoxication in assessing a defendant's capacities which is the subject of AS 11.70.030, relating to intoxication as a defense. McKinney v. State, Sup. Ct. Op. No. 1451 (File No. 2758), 566 P.2d 653, remanded on rehearing on other grounds, 570 P.2d 733 (1977).

Section changed law governing burden of proof as well as insanity test. — The legislature's enactment of this section not only resulted in a change in the basic test

for insanity, but also resulted in substantial changes in the law governing the burden of proof. Alto v. State, Sup. Ct. Op. No. 1443 (File No. 2339), 565 P.2d 492 (1977).

Burden of proof. — See Kinsman v. State, Sup. Ct. Op. No. 914 (File No. 1508), 512 P.2d 901 (1973).

Subsection (b) means that once evidence of insanity is introduced, the burden is on the state to prove sanity beyond a reasonable doubt. Dolchok v. State, Sup. Ct. Op. No. 1006 (File No. 1828), 519 P.2d 457 (1974); Alto v. State, Sup. Ct. Op. No. 1443 (File No. 2339), 565 P.2d 492 (1977).

The burden of proof standard formulated by the legislature under this section is the appropriate standard as to insanity, and the issue of criminal insanity should be decided under the criterion. Johnson v. State, Sup. Ct. Op. No. 888 (File No. 1477), 511 P.2d 118 (1973).

According to subsection (b), the burden of affirmatively proving insanity is not on the defendant. His duty is to introduce evidence supporting this defense; it is the state's burden to then prove that he is sane beyond a reasonable doubt. Alto v. State, Sup. Ct. Op. No. 1443 (File No. 2339), 565 P.2d 492 (1977).

Under this section, once evidence of insanity is introduced, the state is required to prove sanity beyond a reasonable doubt. McKinney v. State, Sup. Ct. Op. No. 1451 (File No. 2758), 566 P.2d 653, remanded on rehearing on other grounds, 570 P.2d 733 (1977).

The defendant who raises the defense of mental disease or defect is no longer required to establish his defense by a preponderance of the evidence. Alto v. State, Sup. Ct. Op. No. 1443 (File No. 2339), 565 P.2d 492 (1977).

The standard requiring a defendant, relying on the defense of mental disease or defect, to present evidence sufficient to convince the court of his insanity is an incorrect standard. Its employment places an undue burden on the defendant and is clearly erroneous. Alto v. State, Sup. Ct. Op. No. 1443 (File No. 2339), 565 P.2d 492 (1977).

Ultimate question where evidence of insanity exists. — Where there was evidence of insanity in a case, the ultimate question is whether the state sustained its burden of proof. Dolchok v. State, Sup. Ct. Op. No. 1006 (File No. 1828), 519 P.2d 457 (1974).

Prosecution need not adduce affirmative evidence of sanity. — There is no rule of law which requires that the prosecution adduce expert or lay testimony or other affirmative evidence to satisfy its burden of proving a defendant's sanity beyond a reasonable doubt. Alto v. State, Sup. Ct. Op. No. 1443 (File No. 2339), 565 P.2d 492 (1977).

Evidence, etc., viewed in light most favorable to state. — In determining the question of whether a judge was mistaken in finding that defendant's sanity was established beyond a reasonable doubt, the evidence and inferences to be drawn from the evidence must be viewed in a light most favorable to the state. Dolchok v. State, Sup. Ct. Op. No. 1006 (File No. 1828), 519 P.2d 457 (1974).

In making the determination as to whether there is substantial evidence to support the judge's finding as to appellant's responsibility for the crime he committed, the evidence and inferences to be drawn from the evidence must be viewed in a light most favorable to the state. Alto v. State, Sup. Ct. Op. No. 1443 (File No. 2339), 565 P.2d 492 (1977).

All inferences are to be resolved in the light most favorable to the state. McKinney v. State, Sup. Ct. Op. No. 1451 (File No. 2758), 566 P.2d 653, remanded on rehearing on other grounds, 570 P.2d 733 (1977).

Substantial evidence. — Where the issue is whether there is substantial evidence to support the judge's finding as to appellant's responsibility for the crime he committed, substantial evidence is such relevant evidence which is adequate to support a conclusion by a reasonable mind that there was no reasonable doubt appellant was sane when he killed his victim. Dolchok v. State, Sup. Ct. Op. No. 1006 (File No. 1828), 519 P.2d 457 (1974); Alto v. State, Sup. Ct. Op. No. 1443 (File No. 2339), 565 P.2d 492 (1977).

Ordinarily, the supreme court's standard for review of findings by a trial judge is the substantial evidence test. The finding below must be affirmed if it is supported by "such relevant evidence which is adequate to support a conclusion by a reasonable mind that there was no reasonable doubt as to appellant's guilt." McKinney v. State, Sup. Ct. Op. No. 1451 (File No. 2758), 566 P.2d 653, remanded on rehearing on other grounds, 570 P.2d 733 (1977).

Substantial evidence to support the trial court's finding of sanity. — See McKinney v. State, Sup. Ct. Op. No. 1451 (File No. 2758), 566 P.2d 653, remanded on rehearing on other grounds, 570 P.2d 733 (1977).

Evidence required before burden placed on state. — Subsection (b) requires that, initially, there must be evidence

supporting a defense of insanity before the burden is placed on the state to prove sanity beyond a reasonable doubt. Christie v. State, Sup. Ct. Op. No. 1644 (File No. 2841), 580 P.2d 310 (1978).

"Some" evidence of the defendant's insanity is sufficient to trigger the state's burden to prove sanity. Alto v. State, Sup. Ct. Op. No. 1443 (File No. 2339), 565 P.2d 492 (1977); Christie v. State, Sup. Ct. Op. No. 1644 (File No. 2841), 580 P.2d 310 (1978).

The state can rely on its cross-examination to sustain its burden of proving sanity once the issue has been raised by sufficient evidence. Christie v. State, Sup. Ct. Op. No. 1644 (File No. 2841), 580 P.2d 310 (1978).

What is "some evidence." — There is "some evidence" of insanity, sufficient to raise the issue, when the evidence presented is more than a scintilla but less than that which would compel a reasonable doubt as a matter of law. Christie v. State, Sup. Ct. Op. No. 1644 (File No. 2841), 580 P.2d 310 (1978).

"Some" evidence means more than a scintilla, yet less than that needed for the entry of a judgment of acquittal. Christie v. State, Sup. Ct. Op. No. 1644 (File No. 2841), 580 P.2d 310 (1978).

Testimony sufficient to raise issue. — Testimony by experts that defendant was psychotic, schizophrenic and was incapable of conforming his behavior to the requirement of the law was sufficient to properly raise the issue of insanity. Alto v. State, Sup. Ct. Op. No. 1443 (File No. 2339), 565 P.2d 492 (1977).

Reference insufficient under "some evidence" test. — One brief reference to the key words of subsection (a) in testimony directed to the issue of diminished capacity, rather than insanity, was insufficient to present a jury question of insanity under the "some evidence" test. Christie v. State, Sup. Ct. Op. No. 1644 (File No. 2841), 580 P.2d 310 (1978).

When the "some evidence" test has been met, a defendant is entitled to an insanity instruction setting forth the state's duty to prove beyond a reasonable doubt that the defendant at the time of the offense had substantial capacity to appreciate the wrongfulness of his conduct or to conform his conduct to the requirements of law. Thus, the ultimate determination of the defendant's criminal responsibility remains with the trier of fact. Christie v. State, Sup. Ct. Op. No. 1644 (File No. 2841), 580 P.2d 310 (1978).

The trial judge must determine initially whether sufficient evidence is introduced to raise the issue of insanity. Christie v. State, Sup. Ct. Op. No. 1644 (File No. 2841), 580 P.2d 310 (1978).

This determination concerns nature of evidence. — The determination of whether sanity is at issue concerns not the quantity of witnesses but the nature of the evidence. Christie v. State, Sup. Ct. Op. No. 1644 (File No. 2841), 580 P.2d 310 (1978).

In deciding whether there is "some evidence" of insanity, the trial judge is not to impinge upon the jury's responsibility to determine credibility of witnesses. Rather, the judge must determine whether a reasonable juror could entertain a reasonable doubt with respect to the accused's sanity. Christie v. State, Sup. Ct. Op. No. 1644 (File No. 2841), 580 P.2d 310 (1978).

Instructions. — The jury should be expressly instructed that the issue of insanity is not to be considered unless it finds the defendant otherwise guilty. State v. Alto, Sup. Ct. Op. No. 1777 (File No. 3748), 589 P.2d 402 (1979).

A verdict of not guilty by reason of insanity contains within it the finding that, beyond a reasonable doubt, the defendant committed the act charged. State v. Alto, Sup. Ct. Op. No. 1777 (File No. 3748), 589 P.2d 402 (1979).

As to waiver of jury trial, the provisions of this section govern. Schade v. State, Sup. Ct. Op. No. 912 (File No. 1620), 512 P.2d 907 (1973).

The question whether there should be a bifurcated trial is committed to the trial court's discretion and will be reviewable on appeal only for abuse. Post v. State, Sup. Ct. Op. No. 1642 (File No. 2851), 580 P.2d 304 (1978).

As to reasons why bifurcated trials often are appropriate where insanity is defense. — See Post v. State, Sup. Ct. Op. No. 1642 (File No. 2851), 580 P.2d 304 (1978).

No statutory right to bifurcated trial. — Subsection (d) refers only to waiver of "a jury trial," which refers to all issues ordinarily tried by a jury. There is no basis for an inference that the legislature intended to create a statutory right to bifurcated trial. Post v. State, Sup. Ct. Op. No. 1642 (File No. 2851), 580 P.2d 304 (1978).

Subsection (d) does not permit a defendant to waive a jury trial on the issue of insanity, while retaining a jury trial on all other issues. Post v. State, Sup. Ct. Op. No. 1642 (File No. 2851), 580 P.2d 304 (1978).

Quoted in Howe v. State, Sup. Ct. Op. No. 1780 (File No. 4129), 589 P.2d 421 (1979).

Cited in Nicholson v. State, Sup. Ct. Op. No. 1519 (File No. 2417), 570 P.2d 1058 (1977).

Sec. 12.45.085. Evidence of mental disease or defect.

Effect of section. — This section merely makes evidence of mental illness excluding responsibility inadmissible in evidence in the absence of written notice of intent to rely on that defense. Christie v. State, Sup. Ct. Op. No. 1611 (File No. 2841), 580 P.2d 310 (1978).

Quoted in Johnson v. State, Sup. Ct. Op. No. 888 (File No. 1477), 511 P.2d 118 (1973).

Sec. 12.45.087. Psychiatric examination.

The conviction of a person who is incompetent to stand trial violates due process of law. Schade v. State, Sup. Ct. Op. No. 912 (File No. 1620), 512 P.2d 907 (1973).

One of the primary reasons for requiring that a defendant be competent before standing trial is to safeguard the accuracy of the guilt finding process. Schade v. State, Sup. Ct. Op. No. 912 (File No. 1620), 512 P.2d 907 (1973).

The defendant must have some minimum ability to provide his counsel with information necessary or relevant to his defense. He must also be able to understand the nature of the proceedings sufficiently to participate in certain decisions about the conduct of the defense. Schade v. State, Sup. Ct. Op. No. 912 (File No. 1620), 512 P.2d 907 (1973).

Some strategic choices must be the product of meaningful communication between the defendant and his counsel. Schade v. State, Sup. Ct. Op. No. 912 (File No. 1620), 512 P.2d 907 (1973).

But this does not mean that a defendant must possess any high degree of legal sophistication or intellectual prowess. Schade v. State, Sup. Ct. Op. No. 912 (File No. 1620), 512 P.2d 907 (1973).

Numerous persons are subjected to criminal prosecution, and properly so, even though they are of relatively low intelligence or are suffering from some significant emotional or physical impairment. Schade v. State, Sup. Ct. Op. No. 912 (File No. 1620), 512 P.2d 907 (1973).

Not every emotional flaw renders one incompetent to stand trial. Schade v. State, Sup. Ct. Op. No. 912 (File No. 1620), 512 P.2d 907 (1973).

. The presence of some degree of mental illness is not an invariable barrier to prosecution. There may be an impaired functioning of some aspects of the defendant's personality and yet he may still be minimally able to aid in his defense and to understand the nature of the proceedings against him. Schade v. State, Sup. Ct. Op. No. 912 (File No. 1620), 512 P.2d 907 (1973).

Standard for determining competency is relative. — See Schade v. State, Sup. Ct. Op. No. 912 (File No. 1620), 512 P.2d 907 (1973).

Where the psychiatric examination of the defendant yields professional findings that he is competent to stand trial, the question of whether to hold any further or evidentiary hearings is addressed to the sound discretion of the trial court. Schade v. State, Sup. Ct. Op. No. 912 (File No. 1620), 512 P.2d 907 (1973).

Physical examination did not violate subsection (a). — A physical examination between a clinical psychologist and defendant shortly after defendant was arrested and taken into custody, because the police feared defendant was suicidal, was properly authorized under AS 33.30.130(a), which specifies the duty of the commissioner of public safety to provide for persons pending arraignment or commitment, and did not violate subsection (a) of this section, and the evidence resulting from it was therefore legally obtained. Loveless v. State, Sup. Ct. Op. No. 1819 (File No. 3320), 592 P.2d 1206 (1979).

Sec. 12.45.090. Commitment after judgment of not guilty.

Origin. — This section has its origin, not in the Model Penal Code, but in the statutes of Oregon which were adopted wholesale for the Territory of Alaska in 1884. State v.

Alto, Sup. Ct. Op. No. 1777 (File No. 3748), 589 P.2d 402 (1979).

A commitment under this section is not indefinite. It should have a fixed length, taking into account individualized factors similar to those relevant to sentencing, and should in no event exceed the maximum sentence for the offense. State v. Alto, Sup. Ct. Op. No. 1777 (File No. 3748), 589 P.2d 402 (1979).

Rights of defendant at post-acquittal hearing. — At the post-acquittal hearing, there may be a six person jury; the defendant is entitled to reasonable notice, to present evidence, to confront and cross-examine witnesses and to appeal; and defendant has the right to be present, and to counsel. State v. Alto, Sup. Ct. Op. No. 1777 (File No. 3748), 589 P.2d 402 (1979).

This section does not state who has the burden of proof or what the standard of proof shall be. State v. Alto, Sup. Ct. Op. No. 1777 (File No. 3748), 589 P.2d 402 (1979).

Burden and standard of proof at post-acquittal hearing. At a post-acquittal hearing, the defendant, to obtain his release, must prove by a preponderance of the evidence that he is not presently suffering from a mental disease or defect which causes him to be a danger to the public peace or safety. State v. Alto, Sup. Ct. Op. No. 1777 (File No. 3748), 589 P.2d 402 (1979).

Equal protection does not require the same standard of proof and the same burden of proof in cases where there has been an acquittal by reason of insanity as in cases where there has been a civil commitment. State v. Alto, Sup. Ct. Op. No. 1777 (File No. 3748), 589 P.2d 402 (1979).

It is not a violation of the due process clause to place the burden of proving insanity on a defendant during prosecution of the case-in-chief. A fortiori, due process does not preclude allocation of the burden of proof to the defendant at the post-acquittal commitment hearing. State v. Alto, Sup. Ct. Op. No. 1777 (File No. 3748), 589 P.2d 402 (1979).

The burden and standard of proof at the periodic review hearings should be the same as at the initial hearing, so long as the commitment under this section is still in effect. State v. Alto, Sup. Ct. Op. No. 1777 (File No. 3748), 589 P.2d 402 (1979).

Burden and standard of proof governing detention following expiration of term of commitment. — Continued detention following expiration of the term of commitment should be governed by the same standard and burden of proof as in civil commitments. State v. Alto, Sup. Ct. Op. No. 1777 (File No. 3748), 589 P.2d 402 (1979).

An instruction substantially in the language of this section should be given whenever it is requested by the defendant. Schade v. State, Sup. Ct. Op. No. 912 (File No. 1620), 512 P.2d 907 (1973).

Applied in Alto v. State, Sup. Ct. Op. No. 1443 (File No. 2339), 565 P.2d 492 (1977).

Sec. 12.45.100. Determination of mental disease or defect during trial or probation. (a) No person who as a result of mental disease or defect lacks capacity to understand the proceedings against him or to assist in his own defense may be tried, convicted or sentenced for the commission of an offense so long as the incapacity endures.

(b) When, after arrest and before the imposition of sentence or before the expiration of any period of probation, the attorney general, the district attorney, or the attorney for the accused has reasonable cause to believe that a person charged with an offense may be presently suffering mental disease or defect or is otherwise so mentally incompetent that he is unable to understand the proceedings against him or properly to assist in his own defense, he may file a motion for a judicial determination of the mental competency of the accused. Upon that motion or upon a similar motion in behalf of the accused, or upon its own motion, the court shall have the accused, whether or not previously admitted to bail, examined as to his mental condition by at least one qualified psychiatrist, who shall report to the court. For the

purpose of the examination the court may order the accused committed for a reasonable period as the court may determine to a suitable hospital or other facility to be designated by the court. If the report of the psychiatrist indicates a state of present mental disease or defect or of other mental incompetency in the accused, the court shall hold a hearing, upon due notice, at which evidence as to the mental condition of the accused may be submitted, including that of the reporting psychiatrist, and make a finding with respect to his mental condition. No statement made by the accused in the course of an examination into his mental competency provided for by this section, whether the examination is with or without the consent of the accused, may be admitted in evidence against the accused on the issue of guilt in a criminal proceeding. A finding by the judge that the accused is mentally competent to stand trial in no way prejudices the accused in a defense based on mental disease or defect excluding responsibility; the finding may not be introduced in evidence on that issue or otherwise be brought to the notice of the jury. (§ 6.11 ch 34 SLA 1962; am § 3 ch 119 SLA 1972)

Editor's note. — This section is set out above to correct an error in subsection (b) as it appeared in the main pamphlet.

Subsection (a) mandate is of constitutional dimensions. — Subsection (a) of this section prohibits the trial, conviction and sentencing of a defendant who cannot assist in his own defense or understand the proceedings against him. This statutory mandate is of constitutional dimensions. McKinney v. State, Sup. Ct. Op. No. 1451 (File No. 2758), 566 P.2d 653, remanded on rehearing on other grounds, 570 P.2d 733 (1977).

The conviction of a person who is incompetent to stand trial violates due process of law. Schade v. State, Sup. Ct. Op. No. 912 (File No. 1620), 512 P.2d 907 (1973); Fajeriak v. State, Sup. Ct. Op. No. 1021 (File No. 1761), 520 P.2d 795 (1974); McKinney v. State, Sup. Ct. Op. No. 1451 (File No. 2758), 566 P.2d 653, remanded on rehearing on other grounds, 570 P.2d 733 (1977).

And his sentence is therefore vulnerable to post-conviction attack. Fajeriak v. State, Sup. Ct. Op. No. 1021 (File No. 1761), 520 P.2d 795 (1974).

This is true whether or not the defendant presented the issue of incompetency at trial. Fajeriak v. State, Sup. Ct. Op. No. 1021 (File No. 1761), 520 P.2d 795 (1974).

But incompetency to stand trial is a concept of restricted application. Fajeriak v. State, Sup. Ct. Op. No. 1021 (File No. 1761), 520 P.2d 795 (1974).

One of the primary reasons for requiring that a defendant be competent before standing trial is to safeguard the accuracy of the guilt finding process. Schade v. State, Sup. Ct. Op. No. 912 (File No. 1620), 512 P.2d 907 (1973).

This section appears to codify the common-law rule. Schade v. State, Sup. Ct. Op. No. 912 (File No. 1620), 512 P.2d 907 (1973).

Common law.

In accord with original. See Schade v. State, Sup. Ct. Op. No. 912 (File No. 1620), 512 P.2d 907 (1973).

This section is patterned, etc.

In accord with original. See Smiloff v. State, Sup. Ct. Op. No. 1637 (File No. 3006), 579 P.2d 28 (1978).

The test in this section is substantially identical to the federal statutory standard of incompetency. Fajeriak v. State, Sup. Ct. Op. No. 1021 (File No. 1761), 520 P.2d 795 (1974).

A defendant need not be proved certifiably incompetent to stand trial before the court is required to order a psychiatric examination. Fajeriak v. State, Sup. Ct. Op. No. 1021 (File No. 1761), 520 P.2d 795 (1974).

Subsection (b) directs only that "reasonable cause" to believe that the defendant may be incompetent to stand trial be shown. Fajeriak v. State, Sup. Ct. Op. No. 1021 (File No. 1761), 520 P.2d 795 (1974).

The defendant must have some minimum ability to provide his counsel with information necessary or relevant to

his defense. He must also be able to understand the nature of the proceedings sufficiently to participate in certain decisions about the conduct of the defense. Schade v. State, Sup. Ct. Op. No. 912 (File No. 1620), 512 P.2d 907 (1973).

Some strategic choices must be the product of meaningful communication between the defendant and his counsel. Schade v. State, Sup. Ct. Op. No. 912 (File No. 1620), 512 P.2d 907 (1973).

But this does not mean that a defendant must possess any high degree of legal sophistication or intellectual prowess. Schade v. State, Sup. Ct. Op. No. 912 (File No. 1620), 512 P.2d 907 (1973); Smiloff v. State, Sup. Ct. Op. No. 1637 (File No. 3006), 579 P.2d 28 (1978).

Numerous persons are subjected to criminal prosecution, and properly so, even though they are of relatively low intelligence or are suffering from some significant emotional or physical impairment. Schade v. State, Sup. Ct. Op. No. 912 (File No. 1620), 512 P.2d 907 (1973); Smiloff v. State, Sup. Ct. Op. No. 1637 (File No. 3006), 579 P.2d 28 (1978).

Not every emotional flaw renders one incompetent to stand trial. Schade v. State, Sup. Ct. Op. No. 912 (File No. 1620), 512 P.2d 907 (1973).

The presence of some degree of mental illness is not an invariable barrier to prosecution. There may be an impaired functioning of some aspects of the defendant's personality and yet he may still be minimally able to aid in his defense and to understand the nature of the proceedings against him. Schade v. State, Sup. Ct. Op. No. 912 (File No. 1620), 512 P.2d 907 (1973); McKinney v. State, Sup. Ct. Op. No. 1451 (File No. 2758), 566 P.2d 653, remanded on rehearing on other grounds, 570 P.2d 733 (1977).

The presence of some degree of mental illness is not an invariable barrier to prosecution. Fajeriak v. State, Sup. Ct. Op. No. 1021 (File No. 1761), 520 P.2d 795 (1974).

That there may be something mentally wrong with a defendant or that he may be emotionally unstable does not necessarily render him mentally incompetent to understand the proceedings against him. Fajeriak v. State, Sup. Ct. Op. No. 1021 (File No. 1761), 520 P.2d 795 (1974).

Not every mental illness necessarily disables a defendant from functioning adequately in a criminal proceeding. McKinney v. State, Sup. Ct. Op. No. 1451 (File No. 2758), 566 P.2d 653, remanded on rehearing on other grounds, 570 P.2d 733 (1977).

The possibility that a defendant might suffer episodes of vertigo or momentary unconsciousness during trial is not enough to render a defendant mentally incompetent. It could with equal justification be argued that a chronically drowsy defendant could not be tried because he might doze off during proceedings. Fajeriak v. State, Sup. Ct. Op. No. 1021 (File No. 1761), 520 P.2d 795 (1974).

Amnesia, be it partial or total, is not an adequate ground for a declaration of incompetency to stand trial. Fajeriak v. State, Sup. Ct. Op. No. 1021 (File No. 1761), 520 P.2d 795 (1974).

Policy cojoins with precedent to oppose an expansion of the doctrine of incompetency to include amnesia. The potential for fraudulent allegations of memory loss is so great that the supreme court would for this reason alone be reluctant to allow amnesia as a ground for a finding of incompetency even if it were otherwise inclined to do so. Fajeriak v. State, Sup. Ct. Op. No. 1021 (File No. 1761), 520 P.2d 795 (1974).

Memory loss, whether partial or total, is not an adequate ground for a declaration of incompetency. Smiloff v. State, Sup. Ct. Op. No. 1637 (File No. 3006), 579 P.2d 28 (1978).

A temporary psychosis, though serious, may not necessarily preclude competency, even where it involves loss of memory. McKinney v. State, Sup. Ct. Op. No. 1451 (File No. 2758), 566 P.2d 653, remanded on rehearing on other grounds, 570 P.2d 733 (1977).

The duty to determine competency is not one that can be once determined and then ignored. Smiloff v. State, Sup. Ct. Op. No. 1637 (File No. 3006), 579 P.2d 28 (1978).

In determining competency, the standard of judgment must be a relative one. Schade v. State, Sup. Ct. Op. No. 912 (File No. 1620), 512 P.2d 907 (1973); Smiloff v. State, Sup. Ct. Op. No. 1637 (File No. 3006), 579 P.2d 28 (1978).

Some comparison must be made between the apparent competency of the accused and the ability level of the average criminal defendant. Schade v. State, Sup. Ct. Op. No. 912 (File No. 1620), 512 P.2d 907 (1973); Smiloff v. State, Sup. Ct. Op. No. 1637 (File No. 3006), 579 P.2d 28 (1978).

To a large extent each case must be considered on its particular facts, and must call for the application of judicial discretion. Schade v. State, Sup. Ct. Op. No. 912 (File No. 1620), 512 P.2d 907 (1973).

The determination is a relative one, and each case must be determined on its own facts. McKinney v. State, Sup. Ct. Op. No. 1451 (File No. 2758), 566 P.2d 653, remanded on rehearing on other grounds, 570 P.2d 733 (1977).

Great deference is to be accorded defense counsel's assessment in matters of defendant's competence to stand trial, insofar as he is better able than the trial judge or the prosecutor to assess the defendant's ability to participate in his defense and to understand the nature of the proceedings against him. Fajeriak v. State, Sup. Ct. Op. No. 1021 (File No. 1761), 520 P.2d 795 (1974); Smiloff v. State, Sup. Ct. Op. No. 1637 (File No. 3006), 579 P.2d 28 (1978).

But his opinion is not determinative. — A defense attorney's duty as an advocate will often require him to present arguments of incompetence on behalf of his client, and while his opinion is still relevant, it is not determinative. McKinney v. State, Sup. Ct. Op. No. 1451 (File No. 2758), 566 P.2d 653, remanded on rehearing on other grounds, 570 P.2d 733 (1977).

The evaluation by defense counsel of the defendant's competency is only of evidentiary value and is not dispositive of the issue. Smiloff v. State, Sup. Ct. Op. No. 1637 (File No. 3006), 579 P.2d 28 (1978).

Where the psychiatric examination of the defendant yields professional findings that he is competent to stand trial, the question of whether to hold any further or evidentiary hearings is addressed to the sound discretion of the trial court. Schade v. State, Sup. Ct. Op. No. 912 (File No. 1620), 512 P.2d 907 (1973); Smiloff v. State, Sup. Ct. Op. No. 1637 (File No. 3006), 579 P.2d 28 (1978).

This section is silent on the procedures to be employed if the psychiatrist's reports indicate that the accused is competent. Smiloff v. State, Sup. Ct. Op. No. 1637 (File No. 3006), 579 P.2d 28 (1978).

Where defendant chooses not to assist in defense. — Although a defendant's decisions may reflect an unwise choice not to aid in his defense, the fact that he chooses not to assist in his defense does not mean he is incapable of doing so. McKinney v. State, Sup. Ct. Op. No. 1451 (File No. 2758), 566 P.2d 653, remanded on rehearing on other grounds, 570 P.2d 733 (1977).

Disagreements with defendant. — Where the main thrust of the trial counsel's showing was the fact that he had encountered difficulties and disagreements with defendant over whether to accept a plea bargain and whether to have a jury trial and defense counsel did not refer to any bizarre behavior on defendant's part or any specific facts indicating defendant's incompetency, the superior court did not err in ruling that a fresh competency hearing was not required. Smiloff v. State, Sup. Ct. Op. No. 1637 (File No. 3006), 579 P.2d 28 (1978).

Limited appellate role on review. — See McKinney v. State, Sup. Ct. Op. No. 1451 (File No. 2758), 566 P.2d 653, remanded on rehearing on other grounds, 570 P.2d 733 (1977).

Viewing the evidence in the light most favorable to the state, the supreme court will examine whether or not there was substantial evidence in the record to uphold the ruling below. If there is substantial evidence, it will not substitute its opinion for that of the trial court. McKinney v. State, Sup. Ct. Op. No. 1451 (File No. 2758), 566 P.2d 653, remanded on rehearing on other grounds, 570 P.2d 733 (1977).

Substantial evidence supporting the ruling that defendant was competent. — See McKinney v. State, Sup. Ct. Op. No. 1451 (File No. 2758), 566 P.2d 653, remanded on rehearing on other grounds, 570 P.2d 733 (1977).

Quoted in Aceveda v. State, Sup. Ct. Op. No. 1531 (File No. 2900), 571 P.2d 1013 (1977).